ROCKY MOUNTAIN MEDICAL JOURNAL

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December 1960, Volume 57, Number 12

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A medical potpourri

Compiled by Andrew M. Babey, M.D., Las Cruces, New Mexico

1. "The cause of chronic glomerular nephritis is unknown, but it is a reasonable precaution to put the patient on daily oral penicillin V in the hope that acute exacerbations after infections with haemolytic streptococci may be avoided." Wardener, H. E. de: Treatment of Disease: Acute and Chronic Glomerular Nephritis, Brit. M.J. 1:561 (Feb. 20) 1960.

2. "The most important advance in the relief of misery in the end stages of chronic renal failure has been the use of chlorpromazine 25-100 mg. by mouth to relieve the vomiting." Ibid.

3. "Before treating the anaemia it is important to remember that patients with renal failure are often unaffected by moderately severe anemia. It is therefore unnecessary in many instance to try to treat the anemia unless the haemoglobin falls below approximately 70 per cent, when it may precipitate cardiac failure. It should also be remembered that in chronic renal failure a rapid rise in the hematocrit (packed cell volume) after a transfusion may cause a sudden deterioration in renal function." Ibid.

4. "Packed red cells are given in small amounts, 100-200 ml. at intervals of two to three days, during which creatinine clearances and the blood urea are measured. The total number of transfusions needed is determined by their effect on renal function and the haemoglobin concentration." Ibid.

5. "At the present time it is not the custom to try to control the level of blood urea by restriction of protein unless the blood urea is rising rapidly or is greater than about 100 mg. per 100 ml." IBID.

6. "It is also debatable whether the acidosis of chronic glomerular nephritis should be treated. It depends on whether the patient feels any better after treatment." Ibid.

7. "The great Frank Wilson, shortly before his death, expressed the disillusioned regret that most people were in greater danger of having their peace and happiness shattered by an erronous electrocardiographic interpretation than of being injured by an atomic bomb." Marriott, Henry J. L.: Coronary Mimicry: Normal Variants, and Physiological, Pharmacological, and Pathological Influences That Simulate Coronary Patterns in the Electrocardiogram, Ann. Int. Med. 52:411 (Feb.) 1960.

8. ". . . it has been well pointed out that the first electrocardiogram is no more reliable than is the initial blood pressure reading in an anxious patient." Ibid.

9. "Severe anemias may produce changes indistinguishable from those of coronary disease; . . . Similarly, acute hemorrhage can cause marked but reversible electrocardiographic changes in both those who have and those who have not any evidence of coronary disease. These changes, moreover, cannot always be correlated with the degree of shock, level of blood pressure or concentration of hemoglobin." Ibid.

10. "It is probably true to say that any acute and many chronic abdominal disorders can seriously disturb the electrocardiogram. Among them, for example, it is well known that such conditions as acute appendicitis, acute pancreatitis and gallbladder disease can mimic the changes of coronary insufficiency or myocardial infarction." Ibid.

11. "The electrocardiograph machine is an instrument of considerable precision, but the interpretation of its precise record is another matter, for the electrocardiogram has a high coefficient of nonspecificity, and it never proclaims the cause of the disturbance it reveals, except by inference. Thus, while it is important to realize that a normal electrocardiogram by no means excludes heart disease, it is even more important to recognize the converse which is indeed the main message of this review—that an abnormal electrocardiogram does not necessarily indicate an abnormal heart." Ibid.

12. "There is a strong possibility that neuropsychiatric complications will develop in cirrhotic patients having a porta-caval anastomosis, presumably due to the by-pass of nitrogenous substances absorbed from the intestine, round the liver, to the brain. . . . Neomycin improves the neuropsychiatric condition of the patients after porta-caval anastomosis." Sherlock, Sheila, et al.: Clinicopathological Conference, A case of Juvenile Cirrhosis Demonstrated at the Postgraduate Medical School of London, Brit. M.J. 1:631 (Feb. 27) 1960.

continued on page 90

Veterans Hospital Abuse—Another Side to the Question

THE ARTICLE ON PAGE 29 of this journal bothers me. The author has made some important points about abuses by the V.A. Hospital hierarchy against John Q. Taxpayer but, in my opinion, the author feels so strongly that he fails to be objective and has created several absurd arguments. Let me make a few rebuttals to several of the points made by Dr. Koontz.

Sure, many V.A. hospitals were created as juicy political plums and were not needed at the time. Many were in isolated communities where they could not be adequately utilized. But how about hospitals such as the V.A. Hospital in Denver? Is there any physician here in the Denver area who feels that the 528 V.A. beds are superfluous? I cannot agree with Dr. Koontz that there are "plenty of vacant beds in the existing hospitals." An excellent survey several years ago stated that this metropolitan area was 1,000 beds short of the need. New beds have been created, but not fast enough.

Two hospitals which I utilize have been running at 93 per cent and 87.5 per cent of occupancy, more than the occupancy rate recommended for best medical care by the American Hospital Association. Every local citizen who has had to wait three or four days with pneumonia before getting into a hospital knows darn well we don't have enough beds. Assuming that at least 50 per cent of V.A. patients need to be in a hospital and that 50 per cent of these are local, if the V.A. were to shut down, local Denver hospitals would have to find room for 130 additional patients.

The Denver V.A. Hospital should not be closed. Now that we are "stuck" with these beds, they should be used. With hospital beds now "costing" over $20,000 each, it would not make sense to fail in taking advantage of beds that cost far less 10 years ago. Who should occupy the beds? Perhaps non-veterans in addition to veterans. Perhaps paying patients in addition to indigent patients. All of us agree that patients with service-connected injuries and ailments deserve full care for those injuries and ailments. We do not all agree that non-service-connected conditions deserve any care in government hospitals. But since the beds are there, I see no objection to indigent veterans receiving care—if they are really indigent!

Several years ago the V.A. tried to eliminate abuse by the wealthy veteran who chisels free medical care for himself. The so-called "pauper's oath" certainly worked with those who were morally honest (or scared), and those men dropped their applications. But our Congress emasculated the law by not allowing investigation of what appeared to be fraudulent financial statements. So abuses still occur (on rare occasions the F.B.I. has been called in).

At any rate, the indigent sick are always going to have to be cared for by the rest of us through our taxes. My bank balance cares very little whether those taxes are federal, state, or local in origin. In our area, the V.A. beds are not a "duplication of local facilities for the care of the indigent." They are a badly needed supplement to local facilities and they will not "necessarily increase our taxes." Very few argue with the government's offer to care for the chronic cases (psychiatric, neurologic, and tuberculous). The remaining medical and surgical beds (about two-thirds of the total) report an average patient stay of 19 days.

Now let me defend the residency program a bit. My own residency was at the Denver V.A. Hospital and I look back upon it as a good one. There are a surprising number of V.A. "graduates" among our local specialist population. At an EKG committee meeting at Porter Hospital last month, five of the 10 doctors in attendance had had V.A. training. Why had they preferred the V.A. residency? In my own case, several good residencies were available but with a wife and three

children to support I'm not sure I could have afforded to take a residency at any other hospital. The V.A. salaries were $2,700, $3,000 and $3,300 for the three years. Was that excessive?

I admit that all private hospitals now have a desperate need for interns and residents, but don't for a minute think that letting the V.A. hospitals "die on the vine" will release doctors enough to alleviate the shortage. In the first place, V.A. Hospitals rarely have interns, only residents. If the V.A. Hospitals were closed, a large number of the patients released would scoot into the neighboring civilian hospitals, necessitating the hiring of an almost equal number of additional residents for their care.

The argument that patients with service-connected disabilities are neglected in favor of care of non-service-connected patients is shameful. The doctor in training is not interested in whether the ailment was incurred in service. If questioned, in many cases he wouldn't even know. He's interested in the patient as a person and as a "case." Sure, acute cases are more exciting and more time and effort are devoted to them. This is true in any hospital. I resent, however, the implication that any of us neglected the service-connected cases. When and if non-service-connected cases are barred completely from V.A. care, are any enthusiastic young doctors going to be attracted to the care of the patients who are left? And are those patients who are left in the hospitals going to be happy with the quality of doctors who are then caring for them?

Let me also defend the managers of V.A. Hospitals who should be righteously indignant about one statement made in Dr. Koontz's article. That was the accusation that "managers of the V.A. Hospitals (are) admitting healthy patients at random and keeping patients in the hospitals for weeks instead of days, in order to keep their census up." If Dr. Koontz wants to blame someone, blame me and other ex-residents. At night as "admitting O.D." I took my turn deciding which patients were entitled to and deserving of admission. During the day the admitting physicians were responsible.

After my residency, I spent six months as a staff doctor in the admission office where I was responsible for deciding about daytime admissions. I was on my own and was never instructed to drag people in to fill up beds. Most often the problem was where to find a bed for a genuinely acutely ill patient. Last year the occupancy rate was 90 per cent. If there were two cases applying for one remaining bed, the service-connected veteran always had priority. Whether service-connected or not, the vast majority of patients were referred in by grateful Colorado physicians.

On the wards, as a resident, I was the one who determined how long my patient stayed. Medical school consultants and private practitioner consultants helped us decide on management and disposition of the cases and either slowed us down or sped us up as indicated. Perhaps we kept many cases too long but that wasn't because the manager told us to do so. The cases were often excellent for teaching and, like all residents, we were reluctant to part with the good ones. Also, of course, we residents were not the family doctors and we could not have patients "drop into the office every three to five days" after discharge. Patients put no economic pressure to bear on us for early discharge relative to their hospital expenses since those were "free." However, almost all the patients were men who were bread-winners for their families, many being paid by the hour, and most of these didn't let us forget that they needed to get back to work as soon as they were able.

I do not like "sops" and doles any more than the next man, and I'm in favor of cutting down on this particular government sop. But let's not cut off our noses to spite our faces insofar as hospital beds are concerned. Let's use intelligent arguments and realize that there are two sides to this question just like there are to every question. And, finally, rather than just offering a list of complaints, let's work on some practical solutions!

James R. Leake, M.D.

Reserve these dates

February 28-March 3, Colorado State Medical Society Midwinter Clinical Session, Denver. April 7-8, Montana Medical Association Interim Session, Helena. May 17-20, New Mexico Medical Society Annual Meeting, Santa Fe.

Veterans hospital abuse and misuse*

Amos R. Koontz, M.D., Baltimore, Maryland

Many readers of this article, especially many veterans, will no doubt be surprised at the title of it. However, the title was not used inadvisedly or without forethought. Neither is the article written by a non-veteran about men who wore the uniform, the author himself being a member of the American Legion, and having served in France for 20 months in World War I and in the Pacific for 43 months in World War II. This article is not written from the point of view of a veteran or a non-veteran, but from the point of view of the average American citizen, who is interested in the welfare of his country.

BY THE ENACTMENT of a seemingly harmless law, a great abuse in veterans' medical care has come about. In the 1920's a law was passed which allowed veterans with non-service-connected disabilities, who were unable to pay the cost of private care, to be taken care of in VA hospitals if there was space available. That "if" was the Ubangi in the cordwood. (I have to speak carefully—the Supreme Court may be listening.) It seems a very harmless provision of the law to allow a needy veteran hospital care if there is space available in the veterans hospitals. (No thought was apparently given by the Congress, which passed the law, to the doctrine of local self-government, upon which this country was founded, and to the fact that the care of the needy is a local responsibility, and not a federal responsibility.) But what happened? It is common knowledge that the privilege has been abused in the most flagrant fashion.

The empire builders

These things are so palpably wrong as to be revolting to any citizen with a sense of decency and fair play. The unsavory condition has been partly responsible for a large percentage of the original consultants, among whom were many outstanding medical figures, either resigning outright or becoming inactive in their VA consulting. Many of the original chiefs of service have left the VA hospitals because they were frustrated by the inept policies and practices of the Veterans Administration.

But what an opportunity for the empire builders! And you may be sure they were not long in grasping the opportunity. Politicians (not statesmen) eager for the veterans' votes clamored to build more and more VA hospitals, even when there were plenty of vacant beds in the existing hospitals. This was really a dish for a congressman if he could get the hospital built in his own district. The result is that now we have many

*Condensed from a paper originally published in the April issue of the Journal of the Mississippi State Medical Association, and copyright, 1960, by the Mississippi State Medical Association. Reprinted by special permission.

more veterans hospitals than we need (172, which treat approximately 500,000 patients a year) and as a rule they are about half empty. This is part of the price that average citizen John Q. Smith pays for getting his congressman re-elected. A further result is that now more than 85 per cent of the patients in our general VA hospitals have non-service-connected disabilities. This has resulted in several evils, which will be discussed seriatim.

System—bad for veteran

The system is bad for the veteran. Many veterans with some semblance of pride left, who would ordinarily never think of asking for free medical care, seeing many other non-indigent veterans with non-service-connected ailments getting on the gravy train, say "Why shouldn't I?" This is a natural reaction. Their taxes are paying for free medical care for their fellow veterans and, although realizing it is wrong, they do it also as a matter of self-defense. The same thing was true of the soldiers' bonus in the 1930's. Many veterans were opposed to it and wrote their senators and congressmen asking them to vote against it. Yet when the bill was passed, they took their share also, because their taxes went into the kitty.

Even if only indigent non-service-connected cases were accepted in veterans hospitals, the system would still be wrong because it is a duplication of local facilities for the care of the indigent. This duplication necessarily increases our taxes. But who would dare think of taxes any more except the politicians who impose them on us? We are supposed to bow our heads and accept the inevitable.

One of the worst features of the VA hospitals, loaded with non-service-connected cases, is the effect that the system has on our civilian hospitals. This is the way it came about: It is common knowledge that before World War II our veterans hospitals were rather miserable institutions, where veterans did not get the best medical care. After World War II the government took steps to remedy this situation. As most veterans hospitals were located near medical schools, the medical schools were asked to form Deans' Committees, who would furnish consultants for the VA hospitals. The object of this was to improve the medical care. (Definite efforts were also made to improve the staffs of the VA hospitals.)

Effect on civilian hospitals

The medical schools accepted this function as a patriotic duty and responded nobly. The consultants appointed by them gave the VA hospitals an academic status. The consultants are largely responsible for the excellence of the residency training programs. The medical schools naturally thought that the part they were playing in the program was to provide better care for disabled veterans with service-connected disabilities, who were returning in great numbers from overseas. But that is not the way it turned out. The affiliation of the medical schools with the VA hospitals enabled the latter to build up tremendous residency training programs and this resulted in enormous expansion of the patient load. This expansion could only have been obtained by the VA hospitals taking in veterans with non-service-connected disabilities, as the number with service-connected disabilities gradually petered out. The VA officials readily admit that they could not carry on their residency training programs without the admission of veterans with non-service-connected disabilities. The medical schools have played an unwitting part in their program.

What do the medical schools get out of it? Of course, the fees for the consultants go to the individual consultants. The medical schools do, however, get some VA grants for research. I am told, though, that these grants are given sporadically and that the medical schools cannot count on a continuing program. They will get an organization set up for a certain research project only to find that the organization has to be disbanded at the end of the year because of a failure to continue the grant for the research. But this is not the real question. The real question is: Is the affiliation of our medical schools with the VA hospitals in the public interest? I doubt if the medical schools have taken the trouble to re-evaluate the situation. What started out as a patriotic duty became a

habit, which is natural, but hardly desirable. But even if the medical schools thoroughly disapproved of the present system, and I believe that most of them do, they could hardly take the stand necessary to abolish the Deans' Committees because there would immediately be raised a hue and cry to the effect that they were against veterans. They are, therefore, in a dilemma not of their own making. However, the present system has resulted in three evils not at all anticipated when it was started.

In the first place, the building up of the residency systems in the VA hospitals has resulted in a depletion of the number of residents available for our civilian hospitals. This has caused the civilian hospitals to accept foreign interns, many of whom are good, but many of whom are undesirable, especially because of language difficulties. If the almost 3,000 residents now in VA hospitals were freed for positions in civilian hospitals, the resident problem in civilian hospitals would be solved.

Duplication of effort

In the second place, it has resulted in a most undesirable type of empire building. More and more veterans hospitals have been built (and probably will continue to be under the present system). Politicians anxious to get votes are only too ready to jump on the bandwagon and squander our money needlessly in a double duplication of effort—namely, double facilities for the indigent (so-called) and double facilities for residency training.

In the third place, the most blatant of all the abuses of the present system is the lamentable fact that patients with non-service-connected disabilities get better care than those with service-connected disabilities. The reason for this, of course, is that those in the former class are mostly acute cases and therefore of more interest to the resident staff and for teaching purposes. Those of the latter class are chronic cases and of not so much interest, and, therefore, they get less attention. Thus we see that the entire object of the VA hospitals—the care of veterans disabled in war—has become thwarted by the empire building bureaucrats.

Solution

What to do about it? We have been working on the problem in Maryland for several years. Our State Medical Society House of Delegates passed resolutions favoring admission only of patients with service-connected disabilities to VA hospitals. We wrote to the other states and got them to support us. At the Dallas meeting of the A.M.A. last December, we succeeded in getting the A.M.A. House of Delegates to pass a resolution requesting a Congressional hearing in the matter. We believe if there was an adequate Congressional hearing and the abuses of veterans' medical care were aired before the public, we could get corrective legislation. We cannot do it unless the public is aware. We can't do it either without the help of all the state medical societies and without all the doctors getting their congressmen to request corrective legislation.

There are people who say that it is impossible to get any legislation affecting the veteran. They say that the veterans are the politicians' pets. I might point out that labor is also the pet of the politicians. Yet in the last session of Congress, a fairly strong labor bill was forced through, really against the will of Congress, who had no appetite for anything but a weak bill, because of the grassroots pressure. We can do the same thing with regard to the abuses in veterans' medical care, but it will take a lot of doing on the part of all of us. The A.M.A. resolution calling for a Congressional hearing was referred to the A.M.A. Council on Legislative Activities. I attended a meeting of the council in January and a committee was appointed to start working right away paving the groundwork for a Congressional hearing as soon as the Presidential election is over.

Result of legislation

Should legislation be passed denying all but service-connected cases admission to VA hospitals, the VA hospitals would die on the vine (except those for tuberculous and psychiatric patients). There would not be enough patients to keep them going. What, then, would happen to the service-connected cases? They could be readily taken care of either in our many service hospitals or public health hospitals, or preferably at home on a home

town care basis. This would save us lots of money (about a billion a year) and it is high time that we were forcing our legislators to cut down on their extravagant spending.

Abolishment of committees

Should the desired legislation not be passed, then I think our Deans' Committees should be abolished. As pointed out before, the medical schools are hardly in a position to take the initiative. The initiative could readily come either from the Council on Medical Education and Hospitals of the A.M.A., or from the Association of American Medical Colleges, or preferably from both. I feel sure that these bodies will not act unless pressure is put upon them. This could come from all of our state medical societies and the A.M.A. Our state medical societies could force the A.M.A. into action just as we did in the Congressional hearing matter. It is up to us. We are still (somewhat) masters of our fate. If the Deans' Committees were abolished, the residency training programs in VA hospitals would fall through and then there would be no further need for their taking patients with non-service-connected conditions. Then we would not have the managers of VA hospitals admitting healthy patients at random and keeping patients in the hospitals for weeks, instead of days, in order to keep their census up.

Before closing this article, I cannot resist the temptation to say something about the cause of all the phony things we see going on around us in this once sane country of ours. With sops to veterans, sops to farmers, sops to labor, sops to every imaginable pressure group, our country is rapidly going on the rocks. I wonder if the American people are still tough enough to reverse the trend. Or are they becoming irretrievably soft—so soft that they no longer care anything for liberty, but only for the type of "security" furnished by a socialistic and paternalistic government. History has shown us that we cannot continue the present trend and survive. Those of us who are still tough must form the hard core for the regeneration of our once great nation.

Spengler and interior decay

Spengler in his The Decline of the West has shown that all the great civilizations of the past have declined, not from outside sources, but from an interior decay. Socialism in one form or another has been responsible in each instance. The peoples of the various civilizations lost their tough fiber, and, instead of maintaining their sturdy independence and individualism, began to seek the ease and comfort that socialistic self-seeking politicians offered them. Thus fell Greece and Rome. Thus were nations and empires emasculated. Some of our present day Western nations have reduced themselves to the same pitiable state. Let us take heed from their example and *not* follow suit. •

Directory listings

The Rocky Mountain Medical Directory listing members of the six states participating in the Rocky Mountain Medical Journal will go to press the first of the year. In the past, every member in each of the participating states received a postcard asking for corrections or additions in their listing. Unfortunately, experience has shown only a 50 per cent return on these postcards and after the directory has been mailed, numerous complaints have been received about incorrect listings. At least two-thirds of the complaints are from physicians who have not returned their corrected cards.

A new system for publishing the directory has been adopted this year and each State Medical Society Secretary has agreed to be responsible for submitting the corrected copy for his state. All members of the six Rocky Mountain states should check their listing as it now appears in the 1960 Directory of Members, and if there are any changes or corrections to be made, notify the Executive Secretary of your State Medical Society.

Physicians who have been elected to membership in the six states after the 1960 Directory was published and are not as yet listed should be certain that the Executive Secretary of their State Society has their correct address. We are endeavoring to publish an up-to-date directory, one which will be of value to everyone, and in order to do this we will need the cooperation of every member who is listed or who should be listed, and is not. The information we will require for a complete listing is name, office address (one only, if you maintain two offices give the major office address), phone number, specialty (if limited please indicate with an asterisk [*]), and type of practice.

Jerked elbow*

W. E. Hess, M.D., Salt Lake City

Ages two to six are subject to this easily diagnosed and treated condition.

SUBLUXATION OF THE RADIAL HEAD from under the annular ligament in children has been called many different names: Pulled elbow[1,2], nursemaid's elbow[1], sprain of elbow, luxation by elongation[3], and Malgaigne's luxation[3]. I have elected to designate it jerked elbow for two reasons. First, the elbow is jerked by a parent, sibling, baby tender, or playmate, and secondly, the one supplying the force is a "jerk" as far as the child is concerned. It commonly occurs as the parent is leading the child through a store by one hand at a rapid gait. The child holds back because the enticing displays command more attention than just a passing glance. The impatient parent jerks the child forward by the hand with the resulting subluxation. I speak as a parent with first-hand experience. Occasionally, it occurs at play with older children and rarely as the child falls out of the crib catching the slats with one hand.

Pathology

The subject is presented at this time because the syndrome seems to be extremely puzzling to the uninitiated. Mothers have told me many times the family physician has examined the child, may or may not have taken an x-ray, and then advised her to give the child an aspirin and bring him back the next day. After a restless night for child and mother, she seeks and obtains more definitive treatment. The pathology[1] is thought to be an incomplete luxation of the proximal end of the radius[2,4,5,6,7,8] produced by a sudden longitudinal pull. In a child age two to six, the circumference of the radial head is the same or smaller than the radial neck[2]. Thus, there is little to keep the annular ligament from subluxating to a position between the capitellum and the radial head when the elbow is hyperextended. By seven or eight years of age, the radial head is relatively larger and jerked elbow does not occur.

The clinical picture is that of a crying child, two to six years of age, carried in by a parent, the child holding one arm stiffly with the elbow in mild flexion (a position of 110 to 135 degrees) and the forearm in midpronation. The child screams and bitterly resists any handling of the involved arm. X-rays, if taken, are negative. The diagnostic features are little or no swelling, pain on any attempted movement, negative x-rays, and the arm held as described above. After one sees a few of these, he has no difficulty with the diagnosis, and x-rays are rarely necessary.

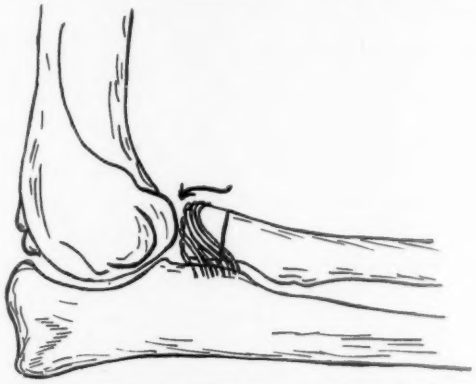

Fig. 1. Lateral view illustrates proximal displacement of the annular ligament with impingement.

*From the Orthopedic Department of the Salt Lake Clinic, 333 South Ninth East, Salt Lake City, Utah.

However, for the beginner, who might confuse the picture with a supracondylar or condylar fracture, x-rays should be made.

Treatment

The treatment is simple. The child's hand is grasped with one hand and his elbow with the other. The forearm is then supinated with a quick, deft motion. There is an audible and palpable click at the elbow, the child cries out, and then within a very few minutes he discovers he can move his elbow once again without pain. Very infrequently, when supination fails to produce the click or reduction, pronation has accomplished the desired result. The ordinary after care consists only of advice to the parents not to jerk or allow anyone else to jerk the child's arm. If the same child returns with a recurrent episode, I then apply a posterior molded plaster-of-paris splint and sling for approximately two weeks. The recurrence rate in my hands is less than 15 per cent. Some[1] recommend application of a collar and cuff sling at the time of reduction. There is no objection to this but my experience with this treatment has been that these youngsters have no subsequent pain and therefore either remove the device themselves or enlist the sympathetic aid of a parent or friend.

Summary

In summary, jerked elbow is a painful condition of childhood ages two to six, easily diagnosed and easily treated if one is aware of the problem. ●

references on page 54

Accident fatalities in Colorado

Roy L. Cleere, M.D.,* Denver

Every statistic represents a human life. Too many are the result of preventable accidents. Only two-fifths of these are due to automobiles.

ACCIDENTS WERE THE FOURTH LEADING CAUSE of death for Colorado residents and also for the United States in 1958, as they were a decade ago. The accidental deaths of Colorado residents, within and outside the state, numbered 1,003 out of 14,391 deaths from all causes in 1958, and 856 out of the total 12,375 deaths in 1949. In both years the accident fatalities equalled almost 7 per cent of the deaths from all causes. The accidental deaths in the United States represented about 5.5 per cent of the total deaths in 1958, as estimated from a 10 per cent sample of the death certificates, in comparison with somewhat more than 6 per cent of the total deaths in 1949.

As shown by the chart and Table 2 regarding fatalities from motor vehicle accidents and from all other accidents per 100,000 population, the annual rates for each of these categories continued higher for Colorado residents than for the United States during the 10-year period, with a few exceptions. Table 1 gives the basic statistics on the accident fatalities and on population estimates for Colorado. On an average, the motor vehicle accident deaths equalled two-fifths of the total fatalities from accidental causes in both the first and second halves of the period.

*Executive Director, Colorado State Department of Public Health.

Death rates from motor vehicle accidents and all other accidents, Colorado residents and United States, 1949-1958
(Deaths per 100,000 estimated population at midyear)

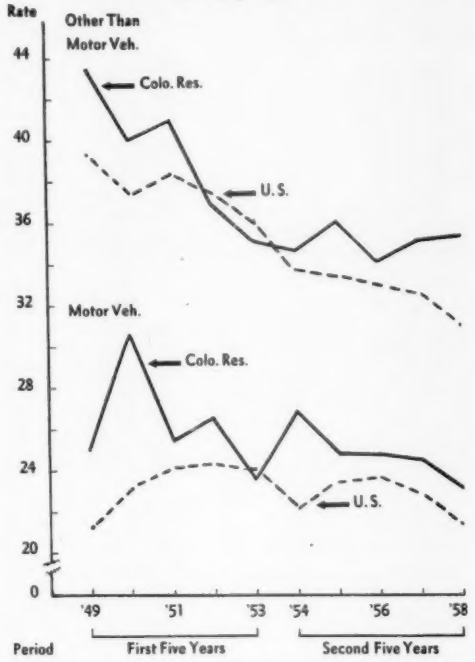

TABLE 1

Motor vehicle and other accident deaths Colorado residents, in and out of state and estimated midyear population

Year	Deaths from accidents Motor vehicle	Deaths from accidents All other	Estimated population
1949	312	544	1,249,000
1950	405	532	1,325,100
1951	349	565	1,376,000
1952	381	528	1,431,000
1953	345	513	1,456,000
1954	403	521	1,499,000
1955	385	559	1,547,000
1956	406	556	1,628,000
1957	410	585	1,663,000
1958	397	606	1,711,000

The motor vehicle accident deaths include fatalities from both traffic and nontraffic accidents involving motor vehicles.

The residence allocation of the state statistics is according to the place of usual residence shown on the death certificates.

Sources: Population—estimates by the U. S. Bureau of the Census; deaths—annual vital statistics tabulations, Records and Statistics Section, Colorado State Department of Public Health.

TABLE 2

Motor vehicle and other accident death rates Colorado residents, in and out of state, and U. S.

(Deaths per 100,000 midyear population)

Year	Motor vehicle Colo. Res.	Motor vehicle U. S.	All other Colo. Res.	All other U. S.
1949	25.0	21.3	43.5	39.3
1950	30.6	23.1	40.1	37.5
1951	25.4	24.1	41.0	38.4
1952	26.6	24.3	36.9	37.5
1953	23.7	24.0	35.2	36.1
1954	26.9	22.1	34.7	33.8
1955	24.9	23.4	36.1	33.5
1956	24.9	23.7	34.2	33.0
1957	24.6	22.9	35.2	32.7
1958	23.2	21.5	35.4	31.1

The motor vehicle accident deaths include fatalities from both traffic and nontraffic accidents involving motor vehicles.

The residence allocation of the state statistics is according to the place of usual residence shown on the death certificates.

In order to average the year to year fluctuations and analyze the main trends for Colorado residents and also for the United States, the median death rates from motor vehicle accidents and from other accidents in the first five of the 10 years were compared with the median rates for the second five years. It was found that the proportionate decrease in the median rates was less for motor vehicle accident deaths than for the other accident deaths, both for Colorado residents and for the United States. The decrease in the median rates was considerably greater for the United States than for Colorado residents in the instance of motor vehicle accidents, but about the same as regards other accidents. The figures are as follows:

	Colo. Res.	U. S.
Motor vehicle accidents		
Median rate 1949-1953	25.4	24.0
Median rate 1954-1958	24.9	22.9
Per cent decrease in median	2.0	4.6
All other accidents		
Median rate 1949-1953	40.1	37.5
Median rate 1954-1958	35.2	33.0
Per cent decrease in median	12.2	12.0

The age distributions of the motor vehicle accident deaths and the deaths from other accidents of Colorado residents, within and

outside the state, in 1958 are shown in Table 3 according to broad age categories. Motor vehicle accident fatalities were most numerous in the age group 25 through 44 years; other accidental deaths were most common in the group aged 65 and older.

The number of accident deaths that occur within the state, regardless of the residence status of the victims, is of concern to the physicians, hospital staffs, and others who deal with the emergencies. In Table 4, therefore, information for 1958 is presented regarding the number of accidental deaths of Colorado residents outside the state, of Colorado residents within the state, and of nonresidents of Colorado who died in this state from accidental causes.

A total of 105 Colorado residents died out of the state from accidental causes, according to the interstate notifications received by the Records and Statistics Section; and 898 died in Colorado. In addition, 150 nonresidents died in Colorado from accidents. Since this classification is based on the place of occurrence of the deaths, not of the accidents, it reflects any movement of fatal accident victims across the state boundaries for care before death. The residence status is based on the usual place of residence shown on the death certificates.

The 898 accidental deaths of Colorado residents in the state in 1958 are distributed in Table 4 according to 12 groupings of the external causes of injury. Motor vehicle accidents head the list, followed by falls in second rank. These two categories account for 60 per cent of the 898 fatalities; motor vehicle accidents for 37 per cent and falls for 23 per cent. Cross tabulations of the fatalities from specific types of accidents with age of the victims reveal many variations in the age distributions, as would be expected from the descriptions of the cause groups in Table 4. Although not abstracted in this brief article, the cross tabulations with age and with other factors are analyzed in special studies from time to time.

Use of statistics

The statistical review and analyses summarized in this report were made by the Research and Reports Service of the Colorado State Department of Public Health.

TABLE 3

Accident deaths, motor vehicle and other, 1958, by age group, Colorado residents, in and out of state

Age group	Motor vehicle	All other
All ages	397	606
Under 5	28	93
5-14	27	45
15-24	96	45
25-44	103	108
45-64	79	92
65 and older	64	223

The residence allocation is according to the place of usual residence shown on the death certificates.

TABLE 4

Accident deaths 1958, by external cause of injury, Colorado residents, in and out of state and nonresidents in state

Residence status and type of accident	Deaths
Deaths of Colorado residents	1,003
Out of the state	105
Motor vehicle, including nontraffic	65
Other	40
In the state	898
Motor vehicle, including nontraffic	332
Falls, except in motor vehicle and other transportation	205
Fire, steam, explosion, corrosive liquid, hot substance, etc.	61
Drowning and submersion, including submersions with small watercraft	60
Mechanical suffocation, from inhalation, ingestion, smothering, etc.	52
Poisoning, by solids and liquids; gas and vapors	34
Firearms, excluding injuries in war operations	33
Transportation, except elsewhere indicated	31
Medical, surgical, therapeutic misadventures, etc.	26
Machinery, except in road transport or on watercraft	25
Results of heat, cold, thirst, hunger, lightning, cataclysm, etc.	20
All other	19
Deaths of nonresidents in Colorado	150
Motor vehicle, including nontraffic	87
Other	63

The residence allocation is according to the place of usual residence shown on the death certificates.

The accident classification is a condensation of the External Cause Code for accidents, in the International Classification of Diseases, Injuries and Causes of Death, 1955 Revision, according to which the deaths were tabulated.

They are based on detailed annual state and county statistics on accidental deaths such as the Records and Statistics Section has machine tabulated ever since 1940, and upon series of National Office of Vital Statistics publications kept in the department's statistical reference collections.

The accident death records and tabulations are used by the department in answering numerous inquiries regarding specific types of accident fatalities and in providing information routinely to various other agencies. For example, summaries of the accidental deaths that occur in the state are sent monthly to the National Safety Council for its compilations on work, home, motor-vehicle, and other public accidents subdivided by external cause of injury and age of victim. Copies of these summaries and also copies of the poisoning death certificates are sent to the Poison Control Center, situated at the Denver Department of Health and Hospitals, a project now financially aided by the State Department of Public Health.

Application of recent National Health Survey rates on injuries per 100 population to the estimated population of Colorado in 1958 indicated that there may be about 475 times as many nonfatal injuries as deaths from accidents among Coloradans, or an estimated 476,425 injuries plus the 1,003 fatalities of Colorado residents in 1958. Prevention of this toll of injury and death is a tremendous problem. It is being attacked in many ways by many types of organizations, including government agencies, traffic control authorities, industries, schools, medical societies, civic associations and numerous other groups. Nevertheless, need to accelerate the downward course of the accident death and disability rates is great, and development of more effective control measures should be stimulated and coordinated in all possible ways. •

Old age pension medical care plan

Policy and benefit changes in Colorado

Paul Hartendorp, M.D.,* Denver

This plan as conceived and now operating is good for the pensionees and is good for our profession. Every plan of this type is beset with problems, chiefly financial and due largely to overutilization. Every participating physician must be thoughtful and unselfish, doing his part to make it survive.

BECAUSE OF INCREASING COSTS of all types of medical care, and because of the large and increasing rate of utilization of medical benefits provided by the Old Age Pension Medical Care Fund to recipients, 32,733, or 56.06 per cent of the 52,000 eligible pensioners, it has become necessary to review carefully the operation procedure and cost structure of the whole program. This includes the following: Drugs in nursing homes, hospitalization, nursing home care, physicians' services, and transportation.

A study of expenditures has indicated that if the current rate continues there will be an overexpenditure of more than $1,200,000 for the year. As the state Constitution limits the expenditure to $10,000,000, retrenchment of the present program is urgently needed. In consideration of how this may be accomplished, the following alternatives are suggested:

*Director, Division of Medical Services, Colorado State Department of Public Welfare.

1. Impose a 21-day limit for hospitalization per admission. Last year, 1959, there were 22,113 hospital admissions. 14,236 people were hospitalized for a total of 261,328 days in 84 hospitals; 8,591 were men, and 13,522 were women. Average length of stay was 11.8 days. About 10 per cent of the total caseload required more than 30 days in hospital stay. Average cost per day was $20.53; average cost per admission was $242.63. It has been estimated that a 21-day limit of hospital stay would effect a decrease of approximately $600,000.

Action taken by the State Board of Public Welfare at its last regular meeting on August 11, 1960, revoked the 30-day regulation for hospital care to 21 days of hospital care per admission, with the provision that in the event of extremely severe illness where additional hospitalization is imperative, or where nursing home care is inadequate, or not available because of no nursing home in the county, or where the hospital is the only place where care can be obtained, then the attending physician should, on the 14th day of hospital stay, make his request for additional hospitalization on Form MED-7, together with sufficient relevant medical information, in order that the processing of these requests be expedited. The Form MED-7 is supplied to all hospitals by Blue Cross.

The Board of Welfare has also imposed a 30-day interval from date of discharge to readmission, when extension of hospitalization beyond the 21-day period has not been properly requested, or has been denied by review of request per letter or telephone communication. There have been instances where patients discharged from one hospital were readmitted on the same day, or the following day, to the same or another hospital, even though the need for continued hospitalization was not medically necessary, but for the purpose of circumventing the 30-day regulation. It is self-evident that considerable expense can be avoided by enforcing this provision.

2. Require prior authorization or consultation by two or more physicians and the Director of the County Welfare Department for elective surgery, i.e., for hernias without obstructive symptoms, pelvic repair in extremely old persons, and also any type of surgery for cosmetic reasons only. (The details of prior authorization will be determined at a later date by joint action of the Department of Welfare and the State Medical Society.) It is expected that decreased expenditures of some $200,000 will be effected.

3. Discontinue the Home and Doctor's Office Call Program. Only 25 per cent of OAP recipients needed this service last year. There has been some misuse of this program by non-eligible recipients, and we have no facilities for good control of improper billing to Colorado Medical Service. Although this is not a large program, its limitations and effectiveness are questioned. The dollar amount expended could be used to better advantage, and amounts to an estimated saving of $500,000.

4. Abolish transportation benefits. This accounts for around $60,000 per year. Nearly all of our recipients have or are able to obtain their own transportation. Exception may be made in extreme cases only.

5. A. Better selective screening of nursing home applicants in determining the need for nursing home care is needed. 4,907 persons—8.40 per cent—received this care in 1959. It has been suggested that we discontinue the classification of nursing home patients, and the Group Rating of nursing homes and, in place of this, scale the rate of payment according to the quality of the home; make additional payment to the base rate for extra equipment, better than ordinary physical plant, recreation area, spaciousness, and attractiveness of surrounding grounds; this to be graded on a simple point system for the purpose of computing the additional amount paid to the nursing home (details to be determined later).

B. Explore the establishing of homes for the aged; for persons not in need of nursing home care but who, because of enfeeblement of age and need for domicilliary care, require this type of shelter and supervised living.

6. A $25.00 or $30.00 deductible plan, or a requirement of the patient to be financially liable for the first two or three days of hospital care in order that utilization for minor-type illness be lessened, and prevent the large number of two and three-day hospital bills we are now required to pay. •

Cushing's syndrome: trends in diagnosis*

Edward H. Rynearson, M.D., William E. Mayberry, M.D., Rochester, Minnesota

Tests stimulating and others suppressing the adrenal cortex form the basis of many of our tests for Cushing's syndrome. More research is still needed, however.

IN A SERIES OF 100 CASES of Cushing's syndrome seen at the Mayo Clinic, the most common signs and symptoms have been rounding of the face, hypertension, truncal obesity, plethora of the face, hirsutism, cervicodorsal hump, purple striae, acne and keratosis pilaris, ecchymoses, and amenorrhea, in that order (Table 1). Until recent years, when measurements of plasma and urinary steroids became available, the more helpful laboratory findings were those of lymphopenia, hyperglycemia, alkalinity of urine, hypopotassemia, alkalosis, hypochloremia, polycythemia, and hypernatremia (Table 2).

TABLE 1

Cushing's syndrome: clinical signs and symptoms in 100 cases

Rounding of the face	92
Hypertension (over 150/90)	90
Truncal obesity	84
Plethora of the face	81
Hirsutism*	74
Cervicodorsal hump	67
Purple striae	64
Acne and keratosis pilaris	64
Ecchymoses	62
Amenorrhea†	35

*There were 81 females, including one child.
†There were 63 females between the ages of 29 and 45.

TABLE 2

Cushing's syndrome: laboratory findings in 100 cases

Lymphopenia	81
Hyperglycemia*	57
Alkaline urine	37
Hypopotassemia	35
Alkalosis	26
Hypochloremia	15
Polycythemia	12
Hypernatremia	5

*Data obtained from 67 cases in which carbohydrate metabolism was adequately studied.

Steroid production

As the biochemical measurement of plasma steroids and the urinary metabolites of adrenal steroids have become available, we have relied increasingly on these determinations in the diagnosis of Cushing's syndrome. Especially we have done so in the less characteristic and atypical cases. Routinely in suspected cases we measure the urinary 17-ketosteroids, urinary corticosteroids, and plasma corticosteroids.

The urinary 17-ketosteroids are so named because of the presence of a ketone group at carbon atom 17 of the steroid nucleus, and

*Read at the 56th Annual Meeting of the Wyoming State Medical Society, Jackson Hole, Wyoming, June 11 to 14, 1959. From the Mayo Clinic and Mayo Foundation, which is a part of the Graduate School of the University of Minnesota.

this is a colorimetric identifying mark of the neutral 17-ketosteroids. The precursors of these metabolites are found in both the adrenal cortices and the testes, and perhaps to a small extent in the ovaries. It is estimated that the testes add perhaps 50 per cent to the production from the adrenal cortices. Because of variations through the day, the measurement is made from a 24-hour collection of urine. In our laboratory normal values range from 6 to 21 mg. per 24 hours for men and 4 to 17 mg. per 24 hours for women. Sprague[1], in analyzing our clinical data regarding this determination, has found that the excretion of 17-ketosteroids is usually high in adrenal carcinoma, low in adenoma, and intermediate in hyperplasia, but that the overlapping among the three is so great that the test does not differentiate reliably in the single case.

As measured by the formaldehydogenic method, the urinary corticosteroids include the intact adrenal hormones and their metabolites that still retain the characteristic side chain of two carbon atoms. Small variations in the procedure may give different results, and therefore values from different laboratories may not agree. Neither the testes nor the ovaries produce gluco-corticoids, and the normal values for men and women do not differ significantly. Normal values in our laboratory range from 0.4 to 1.0 mg. per 24 hours. In Cushing's syndrome associated with adenoma, hyperplasia, or carcinoma, elevated values are common. Such an elevation may be associated with any severe stress, however, and single determinations should not be relied upon.

Under normal conditions practically all the gluco-corticoid activity of the plasma is due to hydrocortisone. The determination of plasma 17-hydroxycorticosteroids (hydrocortisone) is a colorimetric process using 10 ml. of plasma. The plasma concentrations in man are subject to diurnal variation, but values determined at 8 a.m. and 4 p.m. give a fairly good representation of their status during the daylight period. Normal values range from 10 to 22 micrograms per 100 ml. of plasma at 8 a.m. and from 1 to 15 micrograms at 4 p.m. In Cushing's syndrome the values characteristically are elevated throughout the day, with little or none of the normal decrease in the 4 p.m. value. The enigma of the borderline case is not resolved by this test alone, however, because of its wide range of normal values.

Newer tests

Since the nature of the disorder producing Cushing's syndrome has some bearing on the treatment, diagnostic methods short of exploration have been sought; and the newer tests distinguish among the causes besides diagnosing the syndrome. The suggested methods may be categorized as (1) tests stimulating the adrenal cortex with ACTH and (2) tests suppressing the adrenal cortex by use of exogenous steroids such as dexamethasone or Δ, 9α-fluorohydrocortisone.

These newer tests, along with reports of chromophobic pituitary adenomas in some patients with adrenal hyperplasia following total adrenalectomy, have stimulated a renewal of the argument as to the cause of hyperplasia. The benign and malignant tumors of the adrenal cortex that produce Cushing's syndrome are analogous to hyperfunctioning and autonomous tumors arising in other endocrine glands. Time does not permit discussion of this interesting subject, except to say that while the immediate cause of the signs and symptoms of Cushing's syndrome is the excess secretion of hydrocortisone or similar steroids, the ultimate cause of the adrenocortical hyperfunction or hyperplasia is unknown. Although Paris and associates[2] were unable to detect circulating ACTH in patients with hyperplasia, it should be remembered that present methods of assay are not sensitive enough to measure the activity of circulating corticotropin in normal subjects. Consequently, a modest increase in such activity could be present and escape detection by present-day methods of assay.

ACTH stimulation

Forsham and associates[3], in 1948, pointed to the response of the adrenal cortex to exogenous ACTH as a quantitative test of adrenal function. Soffer and associates[4], in 1950, first demonstrated that administration of corticotropin resulted in an excessive response by the hyperplastic adrenal. Thorn and associates[5,6], in 1953, revealed that changes in the

24-hour excretion values of urinary 17-ketosteroids and 17-hydroxycorticosteroids during administration of ACTH had proved useful as an index of adrenocortical capacity. Following the introduction by Nelson and Samuels[7] of a method for determining amounts of 17-hydroxycorticosteroids in blood, the tests for the measurement of plasma levels of cortisol following administration of ACTH were introduced. Eik-Nes and associates[8] were the first to report results of this test from normal and abnormal adrenal states. These several publications provided the stimulus for a great number of reports concerning the measurement of plasma levels of cortisol and urinary levels of 17-ketosteroids and corticosteroids following administration of ACTH in a variety of adrenal abnormalities.

At the present time we rarely use the ACTH stimulation test in either the diagnosis of Cushing's syndrome or the preoperative separation of patients with Cushing's syndrome due to adrenocortical hyperplasia from those whose disease is related to an adrenocortical tumor. Although the patient whose syndrome is associated with an adrenal cortical carcinoma does not respond to a four-hour infusion of ACTH with an increase in plasma cortisol levels, both the patient whose Cushing's syndrome is associated with hyperplasia of the adrenal cortex and the patient whose disease is due to a benign adrenocortical adenoma have an exaggerated increase in plasma cortisol levels; the physician cannot always be sure of separating the two underlying factors. Also, the response to this stimulus in the patient with Cushing's syndrome caused by hyperplasia overlaps to some extent the response in the normal person. For these reasons, we have done practically no ACTH stimulation tests the past three years, relying instead on the suppression test.

At the present time we employ the stimulation tests in Cushing's syndrome most often in an effort to diagnose certain borderline cases, and occasionally in an attempt to decide whether the lesion of the adrenal cortex is hyperplastic or anaplastic. As we administer the test, 25 units of ACTH are suspended in 1,000 ml. of saline and administered intravenously over an eight-hour period. Baseline urinary steroid values are determined for a 24-hour period prior to the test. The plasma cortisol level is determined prior to institution of the intravenous drip and after two and eight hours of its administration. A 24-hour collection of urine is made on the day of the test and the concentrations of 17-ketosteroid and corticosteroid are determined. The procedure may be repeated for two to three consecutive days, depending upon the response.

It has been found by a number of other investigators, as well as by us, that a great deal of overlapping occurs in the adrenal responses of normal people and of those with Cushing's syndrome due to hyperplasia, adenoma, or carcinoma. Usually the rise in urinary 17-ketosteroids is of impressive size only in those patients with syndromes consisting primarily of virilization. Urinary corticosteroids increase by three to five times in normal persons, and by larger multiples in patients whose syndrome is due to hyperplasia or benign anaplasia, but increase little if at all in those whose syndrome is due to carcinoma.

Cortisone suppression tests

Ingle and Kendall[9] showed in 1937 that the administration of corticosteroids over a long period depressed adrenocortical function. Sprague and associates[10] later found inactivation of the adrenal cortex in man following the administration of cortisone, as judged by the urinary excretion of 17-ketosteroid and the response of the eosinophils. This work has formed the basis for the later tests of adrenal suppression. The basis for the suppression tests is that the secretion of cortisol is controlled by the concentration of circulating ACTH, and through a feedback mechanism the secretion of ACTH is controlled by the plasma concentration of cortisol.

The earlier suppression tests employed the only available steroid, cortisone; and suppression was manifested by a reduction of urinary 17-ketosteroids. Values for plasma cortisol and urinary corticosteroid could not be relied upon, because the exogenously administered steroid was included in their fractions. On the availability of Δ, 9α-fluorohydrocortisone, having a gluco-corticoid effect 20 times that of hydrocortisone, Jailer and associates[11] reported its suppressive influence

on cortical function in adrenal hyperplasia. Laidlaw and associates[12], however, employing the drug in treating four patients with hyperplasia, were unable to detect suppression of adrenocortical function. A number of investigators have reported results indicating that the plasma cortisol concentrations in patients with Cushing's syndrome fail to suppress adrenocortical function in the same fashion as do corresponding amounts in normal subjects.

Use of newer steroids

With the recent introduction of the more potent synthetic steroids, several investigators have used these compounds in performing suppression tests. De Gennes and associates[13] have reported recently the suppressive effect of 2 to 4 mg. of Δ, 9α-fluorohydrocortisone per day for two to four days. In four normal controls suppression was almost complete, while among four patients with hyperplasia only one responded with suppression.

At the present time we are employing dexamethasone in suppression tests at the Mayo Clinic. We give 2 mg. in four divided doses daily for three days. If no suppression occurs, we interpret this as evidence that the patient has Cushing's syndrome. We increase the dosage to 6 or 8 mg. per day. If the plasma and urinary steroids are lessened by the larger dosage, we consider the results suggestive of hyperplasia; if no suppression occurs, we interpret this as suggestive of a benign tumor or carcinoma. Our experience with the suppression test is too small to justify any definite conclusions; however, the results to date are encouraging (Fig. 1).

At the meeting of the Endocrine Society in Atlantic City, June, 1959, Dr. Grant Liddle[15] presented the results of the suppression test in patients with Cushing's syndrome. In his hands the test not only was satisfactory in establishing the presence of Cushing's syndrome, but was accurate in distinguishing between patients with Cushing's syndrome associated with adrenal cortical hyperplasia and those whose disease was due to adrenocortical tumor.

Dr. Liddle found further that the administration of 6 or 8 mg. of dexamethasone in four divided doses during the day did result in a significant suppression of the plasma levels of 17-hydroxycorticosteroids in cases of Cushing's syndrome associated with adrenocortical hyperplasia. This decrease, while quite definite and significant, was not so great as one would expect in a normal individual: usually the plasma levels dropped to the range of 10 micrograms per 100 ml.

In addition to the patients with Cushing's syndrome and hyperplasia, he has had opportunity to study several patients with Cushing's syndrome associated with adrenocortical tumor. In these cases the dosage of 2 mg. of dexamethasone daily and also that of 6 or 8 mg. of dexamethasone daily failed to cause any significant fall in the plasma levels of 17-hydroxycorticosteroids. Consequently, Dr. Liddle believes that the so-called suppression test carried out at the two different levels (2 mg. and 6 or 8 mg. daily) not only is a useful procedure in establishing the diagnosis of Cushing's syndrome, but also may prove to

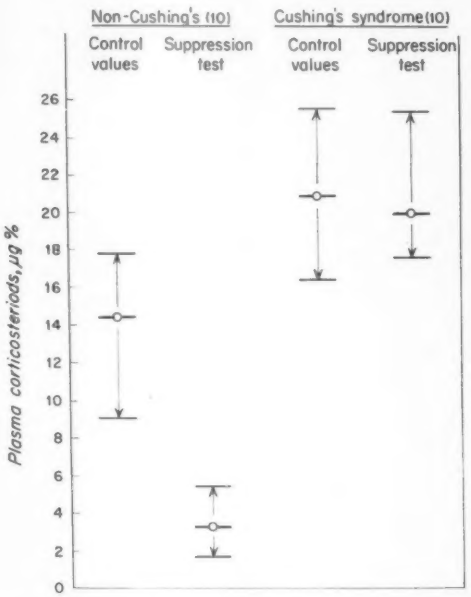

Fig. 1. Results of suppression test in 10 patients with Cushing's syndrome and 10 patients without. Plasma levels of 17-hydroxycorticosteroids were determined by a modification of the method of Silber and Porter prior to administration of steroids and on the third day of administration of dexamethasone or delta-1-9-alpha-fluorohydrocortisone. From unpublished data, courtesy of Dr. R. M. Salassa.[14]

be a reliable procedure for the preoperative differentiation of the cases of Cushing's syndrome due to hyperplasia from those in which it is due to adrenocortical tumor.

Pituitary physiology

At a conference on the basic physiology and clinical application of the anti-inflammatory adrenal steroids held at the Stanford University School of Medicine on March 20, 1959, Dr. Liddle had described the results of his investigations of various disorders of the pituitary—and, in a few cases, Cushing's syndrome—with Su-4885 (a chemical that inhibits 11-beta-hydroxylation in the adrenal cortex). Some patients who had a disorder of the pituitary such as acromegaly, chromoprobe adenoma, diabetes insipidus, or craniopharyngioma, who had normal baseline levels of urine and plasma 17-hydroxycorticosteroids and did not have frank clinical evidence of anterior pituitary insufficiency, failed to show a significant rise in the urinary levels of 17-hydroxycorticosteroids during the administration of Su-4885. This result he attributed to "limited pituitary reserve." A normal individual shows a prompt rise in blood and urinary levels of 17-hydroxycorticosteroids during the administration of Su-4885. This exogenous compound interferes with the synthesis of hydrocortisone, resulting in fall of the plasma levels of this steroid and a consequent increase in the release of ACTH, which stimulates the adrenal cortex. The stimulation results in the appearance of large quantities of compound S in the plasma and tetrahydro S in the urine, and a corresponding increase in the values for 17-hydroxycorticosteroids. The rise in urinary and plasma 17-hydroxycorticosteroids is dependent, however, upon an intact, functioning adrenal cortex and an intact anterior pituitary, at least so far as ACTH is concerned. Patients with limited pituitary reserve usually respond to exogenous ACTH; but, as mentioned before, they do not respond to the administration of Su-4885—presumably because their pituitary is damaged and is not capable of releasing ACTH at an increased rate in response to the fall in serum levels of hydrocortisone.

In the few patients with Cushing's syndrome whom Dr. Liddle has studied, the administration of Su-4885 results in prompt further increase in the urinary and plasma levels of 17-hydroxycorticosteroids when the syndrome is associated with adrenocortical hyperplasia. In a patient with Cushing's syndrome associated with adrenocortical tumor, however, his administration of Su-4885 was followed by a slight decrease of urinary and plasma levels of 17-hydroxycorticosteroids.

Conclusion

Thus, in June of 1959, we are pleased to see so much progress in helping physicians to become more accurate in the diagnosis of Cushing's syndrome; it is obvious that more remains to be done. •

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Nephrotomography and intravenous aortography

Walter S. Keyting, M.D.*, Virgil R. Condon, M.D.†, and A. L. Daywitt, M.D.‡, Denver

An interesting diagnostic aid in renal cysts and neoplasms, vesicular renal lesions, and external masses.

THIS EXAMINATION IS OF GREAT VALUE in consistently and accurately differentiating renal cysts from neoplasms. It also will demonstrate abnormal vascular lesions in the kidney as well as in extrarenal masses. The diagnosis of cysts is based on the relative avasularity of the cyst with well-demarcated margins. Neoplasms may show an abnormal vascular bed on the arteriogram phase film as well as increased or normal opacity during the nephrogram.

Anatomical and physiological basis of nephrotomography

Three basic anatomical portions of renal structure are studied during this examination. The first or arteriogram films show the major vascular supply of the kidney as well as other major abdominal vessels. These films are taken about 10-14 seconds following the start of rapid intravenous injection of contrast material. Following this is the phase in which the capillary bed of the kidney is filled with contrast media. In general, this is apparent about 4-6 seconds after the arteriogram. There is probably some contribution to this phase by glomerular and tubular filtrate[8]. This phase is present for approximately 30 seconds, and timing of this exposure is less critical. The final part of the examination consists of visualization of the renal collecting system, usually of sufficient concentration to nearly equal the quality of retrograde pyelography[1].

History

Historically, nephrotomography had its beginning in 1932 when Wesson and Fulmer first described the nephrogram effect as it was seen in obstructive uropathy[10]. In 1938, Steinberg and Robb actually visualized nephrograms during their studies on cardiac and mediastinal structures with angiography[6]. In 1942, Hellmer described intravenous nephrography as such and Pendergrass suggested the addition of body section radiography[7]. Weens and Florence, in 1947, again described nephrography technic with the addition of tomograms and ureteral constriction[9].

Weens, et al., gave the first complete description of the technic with the use of 70 per cent Diodrast in 1951[10]. In 1953, Porporis, et al., used 70 per cent Urokon sodium for nephrography[4], and in 1954 and 1955, Evans, Monteith and Dubilier published the first complete study on nephrotomography with added emphasis on the arteriogram films[2]. In 1956, Finby, Pokes, and Evans used 90 per cent Hypaque in nephrotomography[3] and, since then, there have been many articles describing the technic, the use of, and the interpretation of nephrotomograms.

Contrast media

In order to obtain sufficient contrast it is necessary to use more concentrated media than is generally used in routine pyelography.

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Some of the earlier workers used 70 per cent Diodrast[10], but with the development of 90 per cent Hypaque[3] and 70 per cent Urokon[4], these media have become more popular. Animal studies by Porporis, et al., showed a kidney tolerance up to 2.5 gm/kg. without evidence of kidney damage or other serious reaction. There are 23 grams present in 50 ml. of 90 per cent Hypaque, and if the results are interchangeable and if the kidney functions normally, the 70 kg. man should tolerate 175 gm. or about 350 ml. Finby[3] in his study with 90 per cent Hypaque noted few serious reactions; however, there was approximately 80 per cent thrombosis at the injection site. Only one in 50 cases developed any phlebitis. It should be mentioned that in the use of the concentrated contrast media that warming the solutions before injection speeds the injection rate. We currently have been using between 50 and 100 ml. of 85 or 90 per cent Hypaque. In case of extravasation, 1 ml. of hyaluronidase is injected into the area of infiltration.

Circulation time

In order to obtain consistent arteriograms, some method of timing of the circulation is needed. Porporis[4], in 1953, used I^{131} with a scintillation counter over the femoral arteries. Evans[1] measured the circulation time with Decholin and added ½-1½ seconds onto the arm to tongue time. Van Velzer and Lanier used I^{131} with a scintillation counter over the abdominal aorta[7]. It is felt that timing by means of a radioisotope is more accurate and yields more consistent results. Good arteriograms were obtained in approximately 50 per cent of the studies reviewed[1]. In our study, when running I^{131} timing simultaneously with Decholin the I^{131} time is consistently several seconds faster than Decholin.

Tomography

The earlier method of nephrography consisted of exposing one KUB film during the time of capillary filling. This certainly was valuable; however, at times there remained

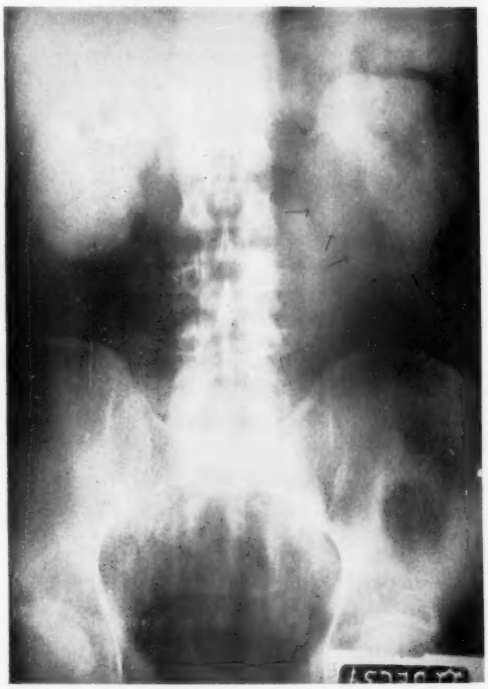

Fig. 1. Two cysts of the left kidney shown by nephrotomogram. These are lucent defects because of avascularity.

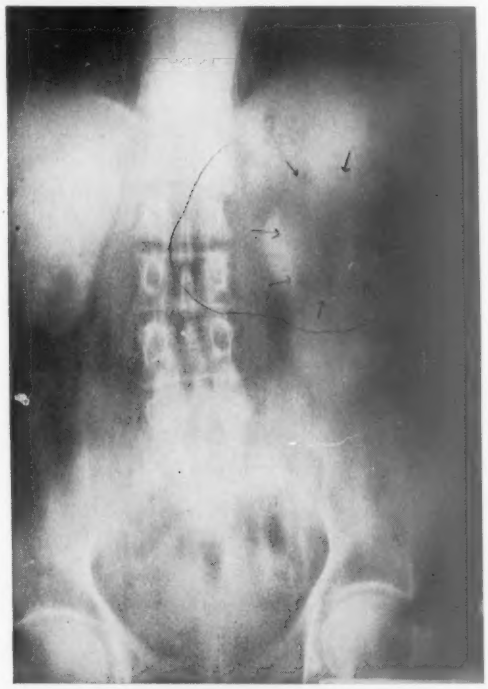

Fig. 2. Lucent defect in left kidney, a cyst. Tumor versus cyst could not be distinguished by IVP or retrograde studies.

certain doubts following the examination in regard to areas of lucency over the kidney. In the studies performed by Evans, et al.,[1] the value of the tomogram in producing a more precise picture of the renal parenchyma was demonstrated. This method eliminates the superimposed bowel pattern and more clearly delineates kidney, cyst, or tumor margins.

Contraindications and complications

As in other intravenous contrast media studies, iodine sensitivity, allergies and severe renal disease are contraindications. Venous thrombosis was not unusual but easily treated, and significant phlebitis was not noticed. Porporis[4] using Urokon 70 in a series of 556 cases had only two serious reactions, and Zink in 350 cases had one case of mild cyanosis and shock, all three of which responded well to adequate therapy.

Evaluation of the examination

Arteriogram films: These films can be expected to reveal disease present in major vessels, such as arteriosclerotic plaques, thromboses, or aneurysms, as well as vascular invasion by tumors. Frequently aberrant vessels as well as variations in the size of renal arteries can be visualized[7]. This is of particular value in the study of renal hypertension. In addition, renal vessels will be displaced around benign cysts while tumors show an abnormal tumor bed stain. Also, since it is usually possible to get satisfactory intravenous aortograms, this method will save the patient the need for a general anesthetic and translumbar aortic puncture with its inherent risk.

Capillary phase: These films reveal areas of relative radiolucency representing cystic areas as opposed to neoplastic masses that show abnormal radiodensity or density equal to renal parenchyma[1]. Cysts are well demarcated with smooth margins and are definitely radiolucent[2]. Neoplasms are less well marginated and may have an indistinct margin as well as a slightly lucent center if the lesion is necrotic centrally. These findings are accentuated by the use of tomography, usually at two different levels. If, as stated by

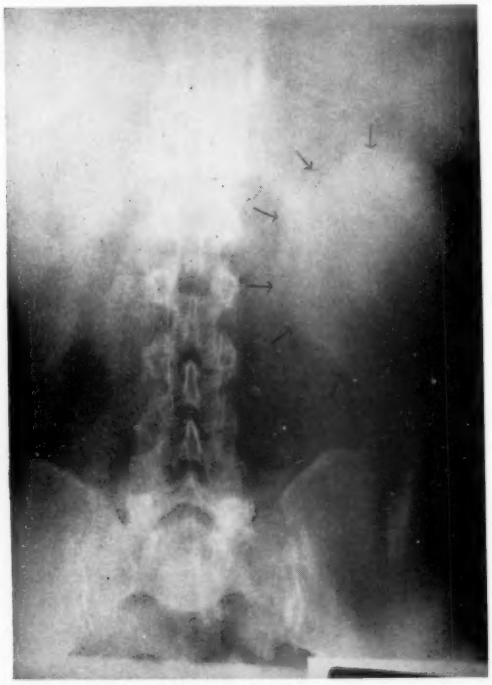

Fig. 3. Highly vascular lesion, left kidney, shown by nephrotomogram, a hypernephroma. Renal vein involvement was correctly predicted because of nonfunction on IVP.

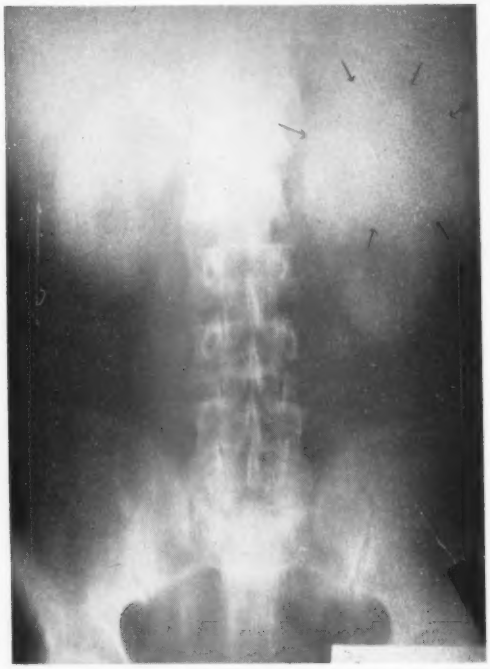

Fig. 4. Another highly vascular lesion of the left kidney, a hypernephroma.

Spence[5], a substantial per cent of hemorrhagic cysts are malignant, these would be missed on nephrotomograms; however, definite proof of this statement seems lacking.

Excretory films: These films reveal the finding that normally would be seen on routine IV urography studies in relation to displacement or abnormalities of collecting system structures. However, it should be mentioned that the quality of these examinations frequently approaches the quality of retrograde examinations. Also, a certain measure of renal function can be determined by the excretory films. We find it of considerable value to include a tomogram in the excretory series.

Current technic

1. Preliminary timing using 50 microcuries of RISA and scintillation counting over the abdominal aorta is carried out with the routine iodine uptake apparatus and a graphic recording of the count rate is obtained.

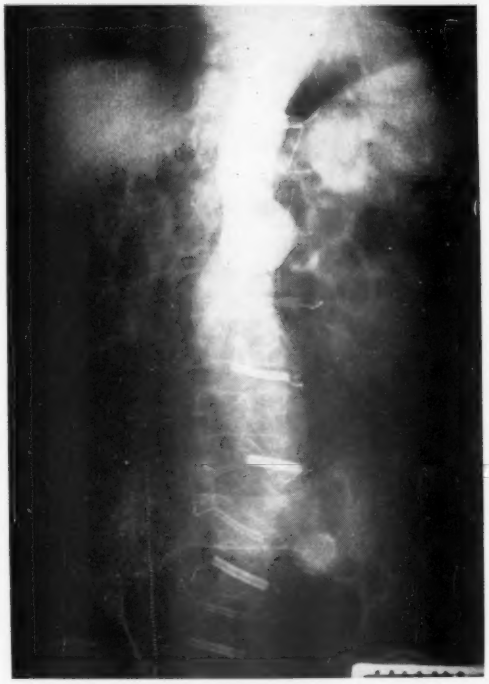

Fig. 5. Aortogram from venous side shows aneurysm at level of renal arteries and aneurysmal dilatation of the lower abdominal aorta. Nephrogram film 4 seconds later revealed lower aneurysm to be in left hypogastric.

2. Preliminary scout KUB tomogram is obtained. This serves to check the level for the nephrotomograms as well as the usual purposes of the scout film. The tomograms are cut approximately 1 to 3 cm. dorsal to the coronal plane.

3. Injection—the antecubital area is anesthetized with Xylocaine. Thirteen gauge needles attached to 50 ml. syringes filled with 90 per cent Hypaque and inserted percutaneously bilaterally and a test dose is given. Then rapid manual injection is accomplished, the needles are withdrawn, and the area is bandaged.

4. The following series of films is obtained:

a. Arteriogram film—KUB technic at the precise predetermined circulation time, using 2-second exposure.

b. Nephrogram film—KUB technic with rapid manual change.

c. Nephrotomograms (2 films) at levels 2 cm. apart. (These first four films are taken within approximately 30 seconds.)

d. Routine excretory urogram films in-

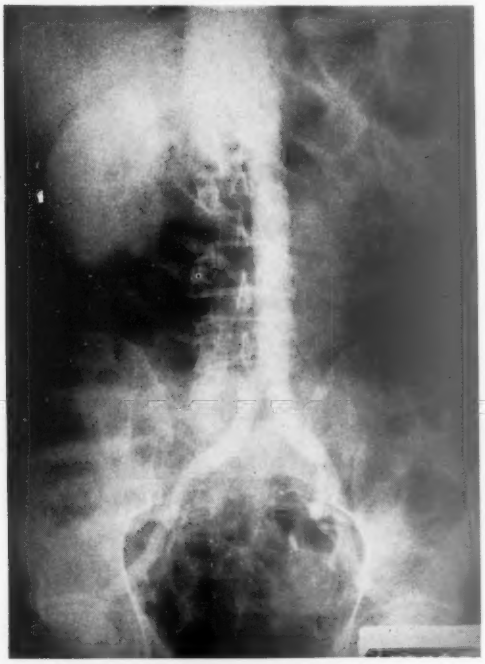

Fig. 6. Relatively normal aortogram from venous side. There is an atheromatous plaque of the superolateral aspect of the right common iliac.

cluding oblique films at 12 minutes and one tomogram at 10 minutes.

Complications in our experience

Nausea and vomiting is comparable to that seen with routine intravenous urography. Flushing is present in almost all cases but passes quickly and is not a significant factor. Thrombosis at the injection site has been noted but not to the extent described by many authors. Extravasation has been infrequent but successfully treated by hyaluronidase (one case of minimal necrosis). Phlebitis has been rare, with only one case of minor phlebitis that responded rapidly to local measures.

Results and conclusion

We feel that this examination offers a consistently reliable method of differtiation of cysts and neoplasms, plus offering other findings of diagnostic value. It must be admitted that the method is not infallible, and if there is any reasonable doubt as to the diagnosis, exploratory surgery is indicated. However, many cases will be quite diagnostic, and certainly when the two lesions can be differentiated, a poor risk patient can be spared exploratory surgery. We have not been able to make unequivocable diagnoses in all cases and have not been 100 per cent accurate; however, in the two proved misdiagnoses the lesions which were thought to be tumors were proved to be cysts. Considering the technic of the examination, this is the type of error to be expected and this is not felt to be detrimental to the patient or the examination.

In addition, the arteriogram films have demonstrated aortic aneurysms, arteriosclerotic plaques, aberrant vessels, and in one case of hypertension, a small renal artery and kidney were visualized. This finding was confirmed at autopsy. Recently, diagnostic aortograms have been abtained in over 75 per cent of our examinations.

As mentioned previously, the excretory urogram films were of a much better quality and, in general, were comparable to those seen in retrograde pyelography. •

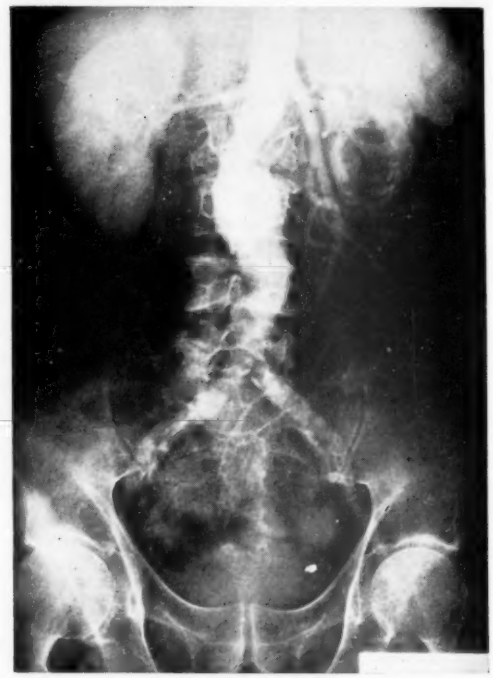

Fig. 7. Aneurysm of mid-abdominal aorta below renals plus severe atheromatous disease distally. Hypogastrics are blocked. Note intact renal arteries and superior mesenteric from left side of aorta.

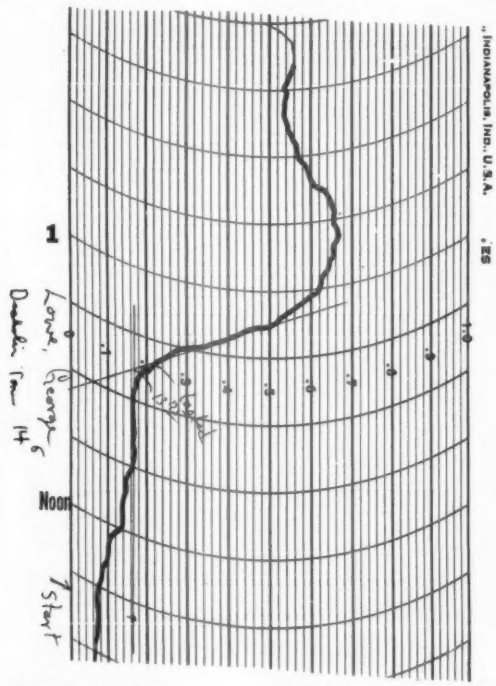

Fig. 8. Graph recording I^{131} circulation time, antecubital vein to abdominal aorta at level of renal arteries.

references on page 54

THE WASHINGTON SCENE

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

Election of Sen. John F. Kennedy as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and x-rays and laboratory tests on an out-patient basis," he said in his campaign for the Presidency.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion and modernization of medical, dental and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research, and expansion of federal programs for rehabilitation of handicapped or disabled persons.

Food and Drug Administration employees have been cleared of conflict-of-interest charges brought up in the Senate Antitrust and Monopoly Subcommittee's investigation of the drug industry.

A three-member investigating group appointed by Arthur S. Flemming, Secretary of Health, Education and Welfare, examined the financial records of 900 FDA employees. The special investigators then reported:

"On the basis of all the evidence before us, it is our judgment that there are no present employees of the FDA whose sources of personal income are incompatible with their government employment."

The investigators continued to analyze "a mass of fact and opinion" in connection with charges that there has been too close a relationship between some FDA employees and drug companies which they check for conformance to government regulations.

The investigators anticipated that their final

report would show the possibility of organization or procedural improvements in the FDA.

The charges were triggered by disclosure at the subcommittee investigation that Dr. Henry A. Welch, Director of the FDA's Antibiotics Division, had received $287,000 over eight years as a writer and editor for antibiotics publications. After the disclosure, Flemming ousted Welch from the government post.

The Federal Children's Bureau reported that the infant death rate in the United States has declined since 1958 but still shows the effect of a 1957-'58 setback.

There was a steady decline in U. S. infant deaths during the 1950's but increases in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 deaths under one year per 1,000 live births) and the first half of 1960 (25.9 per 1,000) showed improvements.

In 1915, when data were first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940, this had been cut to 47 and by 1950, it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were: Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4 and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data were reported.

Persons with heart and blood vessel diseases have been urged to consult their physicians about routine vaccination against influenza.

In a joint statement, the American Heart Association and the National Heart Institute of the U. S. Public Health Service said that "evidence of the past three years abundantly confirmed that dangers of influenza are much greater for patients with heart or lung disease than for others." The risk was described as "particularly high for those with lung congestion due to heart disease."

The joint statement added that three recent influenza epidemics had "again emphasized the fact that individuals with cardiovascular or pulmonary disease are more susceptible to the hazards of influenza than is the general population." The epidemics were in the fall of 1957, the spring in 1958 and early this year.

The increased risk was shown both by more severe illness and by higher fatality rates among patients with heart and blood vessel disease, the statement said.

The association and the federal agency said influenza virus vaccine had been shown "of definite value" in preventing the disease. Side reactions were reported as "extremely few."

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Nephrotomography cont. from page 48

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"Reflexes—Adequate."

Abstract of Minutes*
House of Delegates of the Colorado State Medical Society

Ninetieth Annual Session
September 14 to 17, 1960
Stanley Hotel, Estes Park, Colorado

FIRST MEETING

Wednesday, September 14, 1960

Speaker William M. Covode called the House to order at 10:00 a.m. and he and Vice Speaker H. R. Bull alternated in presiding throughout the session. Dr. John A. Davis, Chairman, reported for the Committee on Constitution, By-Laws and Credentials, certifying Delegates' names as printed on pages 4 and 5 of the Handbook with the exception of the Delegate from the Otero County Medical Society, which he reported as delinquent in filing its annual report.

Fifty-five Delegates answered the initial roll call, more than a quorum. Before adjournment, attendance of accredited Delegates increased to 62. On motions of Dr. John A. Davis, the Delegate from Otero County was seated in spite of that Society's delinquency and the credentials report of Dr. Davis' committee was adopted.

By action of the House at the February, 1960, interim meeting, the first order of business at this Annual Session was consideration of the Constitution and By-Law amendments proposed one year ago and approved by the House in February. This special unfinished business was printed beginning on page 9 of the Handbook.

Following explanations by Speaker Covode, Dr. Cyrus W. Anderson, Chairman of the Ad Hoc Committee on By-Law Revision, and Dr. John Davis for the Committee on Constitution, By-Laws and Credentials, Dr. Davis moved that the amendments to the Constitution and By-Laws as printed in the Handbook be adopted. The motion carried without dissent, and the Speaker declared the Constitution and By-Laws so amended.

On behalf of the Constitution and By-Laws Committee, Dr. Davis then introduced the following additional By-Law amendments to be considered at this session:

"On page 11 of the Handbook, in Chapter VI, Section 1, at the bottom of the page, insert a sentence as follows: 'The Chairman or Acting Chairman of the Board of Councilors and of the Grievance Committee shall be ex-officio members of the Nominating Committee, without right of vote.'

"On page 14 of the Handbook, in Chapter VIII, Section 2, after the words 'shall form the Advisory Committee,' add the following: 'The two immediate past Presidents of the Society may attend the Advisory Committee as ex-officio members, without privilege of vote.'

"On the same page and same section, delete the words beginning with 'and shall' and ending in 'public relations.' The committee considers that this is superfluous and unnecessary.

"Then in your By-Laws booklet on page 34, Section 4 under Chapter XI, 'Component Societies,' the section entitled 'Jurisdiction over Physicians in District,' the committee recommends that the following be added: 'Physicians in full-time state or federal governmental service of a national or state-wide nature may elect to be members of the society of their residence or central place of employment.' "

The above proposals were re-referred to the Committee on Constitution, By-Laws and Credentials in its reference committee capacity for a later report.

The Speaker ruled that to avoid confusion at this Annual Session he would continue to recognize the nomenclature of boards, committees and subcommittees as printed in the Handbook, rather than the new nomenclature under the amendments just adopted, pending completion of reference committee reports at this session.

With Vice Speaker Bull presiding, Speaker Covode then addressed the House briefly and announced that the Hon. Stephen L. R. McNichols, Governor of Colorado, would address the House today. He asked President John L. McDonald to introduce the Governor.

Governor McNichols then addressed the House at length, expressing his appreciation for the Society's cooperation in developing a new approach to the problems of mental health in Colorado, presenting the state's financial problems with regard to the old-age pension medical care plan, and requesting continued cooperation of the Society and the medical profession in holding down the costs of this program.

Speaker Covode thanked Governor McNichols and assured him that the Society would give serious consideration to all of his proposals.

Minutes of the House meetings at the February, 1960, Clinical Session were presented, and there being no corrections or objection, they were

*Condensed from the permanently filed shorthand record of Bertram Naster, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates at the 90th Annual Session, in the printed "House of Delegates Handbook," or were distributed to all members of the House in mimeographed form. Copies of all such reports are on file with the Executive Office of the Society, and with the Secretary of each component Society, available for study by any member of the Society.

approved as published in the May, 1960, issue of the Rocky Mountain Medical Journal.

President McDonald presented the annual report of the Board of Trustees as published in the Handbook, a mimeographed supplement presenting the annual audit by an independent firm of certified public accountants, and a mimeographed supplement presenting actions of the Board of Trustees subsequent to the publication of the Handbook. He then asked Dr. Carl W. Swartz, member of the Board of Trustees, Chairman of the Finance Committee, and Chairman of the Board's Ad Hoc Committee on Retirement Plan, to present an additional supplemental report.

Dr. Swartz addressed the House as follows:

"You have in your hands two brochures, one of which is a copy of the trust agreement with the bank. The other is the brochure of the investment program itself.

"Your ad hoc committee was created by action of the House last February. It has met and studied this problem from every possible aspect. Its subcommittees have spent many hours in discussions. It was felt best to proceed with or without the passage of Keogh-type legislation, but, of course, it is perfectly adaptable to such legislation as we now know it, if such is passed. At least we will have a vehicle for a good investment program available to Colorado doctors, even if no legislation passes.

"Bids were solicited from three leading Denver banks to act as our trust department. Their three replies were carefully studied and the Colorado National Bank was selected as the most satisfactory to our needs and wishes.

"Specifications were then drawn up for presentation to 16 insurance companies for bids on an insurance program to fit the needs of our plan. Bids were received from six companies. These were weighed and compared, and the best bid was found to be a combination of a Colorado company and a national company. Extreme interest and cooperation of these companies have made our work load easier.

"After your Board of Trustees had accepted the bid of these companies, some other companies have seemed more interested and have circularized some of our membership. Remember that these same companies had a chance to bid earlier and failed to show enough interest to put in a competitive bid.

"Progress has been made possible through the combined efforts of the committee, its co-ordinator and adviser, Mr. J. Merle Lemley, the bank's trust officers, and the active and progressive actions of the insurance companies selected.

"At this time, I should like to introduce Mr. Merle Lemley and to introduce the representatives of the bank and the insurance companies involved."

Mr. Lemley addressed the House briefly and introduced Mr. Stuart Ferris, Vice President of the Security Life and Accident Company of Denver, and Mr. Kenneth Caughey, a trust officer of the Colorado National Bank, each of whom thanked the Society for the confidence placed in their institutions. Mr. Lemley outlined the eight months of specialized work and research that had gone into development of the Colorado State Medical Society Unified Retirement Investment Trust. President-elect Cyrus W. Anderson closed the discussion, paying high compliments to Mr. Lemley and the other experts who developed the plan with the ad hoc committee.

Speaker Covode referred all the reports of the Board of Trustees to the Reference Committee on Board of Trustees and Executive Office, including the special report of the Ad Hoc Committee on Retirement Plan.

The Chair again recognized President McDonald to present nominations on behalf of the Board of Trustees for Certificates of Service. The following citations were read:

CITATION
WILLIAM H. HALLEY, M.D.

Lest it be forgotten by younger members of our profession, let our opinion be recorded that Dr. William H. Halley did more than any other Coloradan—and he was one of a scant dozen similar leaders in the nation—to bring about a modernization of the American Medical Association in those postwar years of 1947 to about 1954. The 1947 modernization of our own Colorado State Medical Society in which Dr. Halley played a major role, formed a pattern for the A.M.A. reorganization.

He entered the House of Delegates of the A.M.A. in January, 1947, with the prestige of a Past President of both the Denver County and the Colorado State Medical Societies, and was one of a small group who in three years attracted under their leadership a majority of that House. He and they inspired, "needled," if you will, and finally convinced their confreres to the end that the House of Delegates itself, rather than a small hierarchy dominated by one ambitious personality, would thereafter establish policies for American Medicine. Much of this was accomplished by Dr. Halley's column, "Silhouettes from the A.M.A. House of Delegates," which he wrote monthly for our Rocky Mountain Medical Journal through 1947, '48, '49. Those writings, together with an independent public relations survey report to the A.M.A., are properly credited with causing the creation and development of a modern public relations program and department of our national organization. For many years national observers referred to California, Colorado and Michigan as the "big three" states which led the A.M.A. to its modern democratization. Dr. Halley was the man most responsible for Colorado's inclusion as one of the "big three," and we should all remember that Colorado had only 1 per cent of the membership in the A.M.A. House of Delegates.

On occasion, Dr. Halley's pen and speech alike could be charged with acid when deep etching was needed, but both were always guided by his abiding principle that the interests of his own and every physician's patients came first. Even when cutting sharply into the center of the problem, his actions and his words always bespoke a kindly and understanding tolerance of all men's honest errors in judgment.

The burdens of his heavy practice were never too great to prevent Dr. Halley from serving actively and with distinction on committees and in minor offices where personal recognition seldom, if ever, resulted. Some physicians have retired from service to their state medical societies, "retired on their laurels," so to speak, after having achieved and completed the high office of President. In contrast, Dr. Halley's greatest services to our Society and to American Medicine were performed throughout the 15 years following his 1941 Presidency of our Society.

Your Board of Trustees is therefore convinced that William H. Halley, M.D., has richly earned and deserves the Certificate of Service of the Colorado State Medical Society, and on its own motion so nominates him to the House of Delegates.

CITATION
BRADFORD MURPHEY, M.D.

"Dr. Bradford Murphey has given generously and unselfishly of his time, energy and counsel to the profession, governmental bodies and voluntary health agencies in the interest of medicine and public health and welfare for two decades.

"He participated in the establishment of programs which have altered the position of the medical profession in the fields of legislative activity and public relations. The United Public Health League, which he helped to found in 1945, was the forerunner of the Washington office of the American Medical Association. The League was organized to represent the views of physicians from 11 Western states before Congressional bodies considering legislation of a medical nature.

"When Raymond Rich and Associates were retained by the State Medical Society to study the public relations of the medical profession in Colorado, Dr. Murphey assisted in setting up the study and worked for implementation of recommendations arising from it. He was also a charter member of Colorado's original Code of Cooperation Committee representing medicine, hospitals, press and radio.

"In addition to three years' service on the State Medical Society's Board of Trustees, Dr. Murphey has served as President of the Denver Medical Society, is currently on its Board of Trustees and is Chairman of the Library Policy Committee, among many other assignments.

"At the same time he was active in medical society

affairs, Dr. Murphey found time to ably represent the medical profession as an official spokesman or private public service-minded individual to several social and voluntary health organizations. His service on civic projects as a citizen and medical society representative, encompasses participation in conferences and on Councils sponsored by local, state and national governmental units, and he continues to serve many worthy projects and programs concerned with improvement of the welfare and health of his fellow man.

"No one physician more richly deserves the Certificate of Service, the highest recognition his medical society can confer upon him."

Your Board of Trustees has considered the above citation submitted by the Denver Medical Society, heartily endorses it, and so nominates Dr. Murphey.

CITATION
CARL A. McLAUTHLIN, M.D.

"Dr. Carl A. McLauthlin has served his profession and the public faithfully and conscientiously through his many years of volunteer service at the Denver General Hospital. He has served the Colorado State Medical Society as an elected delegate to its House of Delegates and has been a leader of his colleagues as President of his component society and later as Chairman of its Board of Trustees.

"He was active in the planning and construction stages of the Denver Medical Society Library which upon completion has been able to offer improved library services and facilities to all physicians in the Rocky Mountain region, and a convenient location in which to hold meetings.

"Dr. McLauthlin was instrumental in establishing the first Emergency, Referral and Information Service in this region almost 12 years ago. This has been a valuable service offered to the public without charge. Under his guidance, this service has grown and expanded until it now processes almost 60,000 calls a year. The confidence of patients, co-operation and faith of physician participants and the leadership of Dr. McLauthlin have been factors which have given the profession this public service project of which it can be justly proud.

"Dr. McLauthlin's keen interest in the education of new physicians has resulted in the establishment of an interest-free loan fund to aid needy and worthy medical students at the University of Colorado School of Medicine. This fund was established by Miss Grace I. McNaught in the memory of her father, Dr. Francis H. McNaught, a pioneer Colorado physician.

"In a sincere and quiet manner, Dr. McLauthlin has worked for the best interests of the medical profession and he has earned one of life's greatest rewards, the satisfaction of accomplishment."

Your Board of Trustees has considered the above citation submitted by the Denver Medical Society, approves it, and so nominates Dr. McLauthlin for this Society's Certificate of Service.

On motion of Dr. John H. Amesse, unanimously carried with applause, the House confirmed the above nominations for Certificates of Service.

The Handbook reports of the Board of Councilors and Grievance Committee were received and referred to the Reference Committee on Professional Relations.

Under the order of optional individual reports by officers, President McDonald then addressed the House at length.* Dr. McDonald's report was referred to the Reference Committee on Legislation and Public Relations.

The Handbook report for the A.M.A. Delegation and their reports appearing in the August and September issues of the Rocky Mountain Medical Journal were introduced by Dr. Kenneth C. Sawyer, senior A.M.A. Delegate, who informally expanded these reports with discussion of procedures at the A.M.A. House of Delegates.

Dr. I. E. Hendryson, A.M.A. Delegate, pointed out that since the reports had been written by Dr. Sawyer they failed to mention honors and recognition which Dr. Sawyer had received. Dr. Hendryson paid high tribute to Dr. Sawyer for his accomplishments in the A.M.A. House.

The Handbook reports of the Foundation Advocate and the Executive Secretary were received and referred to the Reference Committee on Board of Trustees and Executive Office.

A mimeographed supplemental report of the Executive Secretary, suggesting that certain long-established Standing Rules of the House of Delegates might be considered for inclusion in the By-Laws which will be reprinted soon, in any case, was referred to the Reference Committee on Constitution, By-Laws and Credentials.

On behalf of the Board of Councilors, the Executive Secretary presented another mimeographed supplement wherein the Board of Councilors recommended a By-Law amendment to give physicians in full-time governmental employment eligibility for membership in the component society holding jurisdiction over their residences. This was also referred to the Reference Committee on Constitution, By-Laws and Credentials.

The House recessed at 12:15 p.m. for lunch and reconvened at 2:00 p.m. with a quorum present.

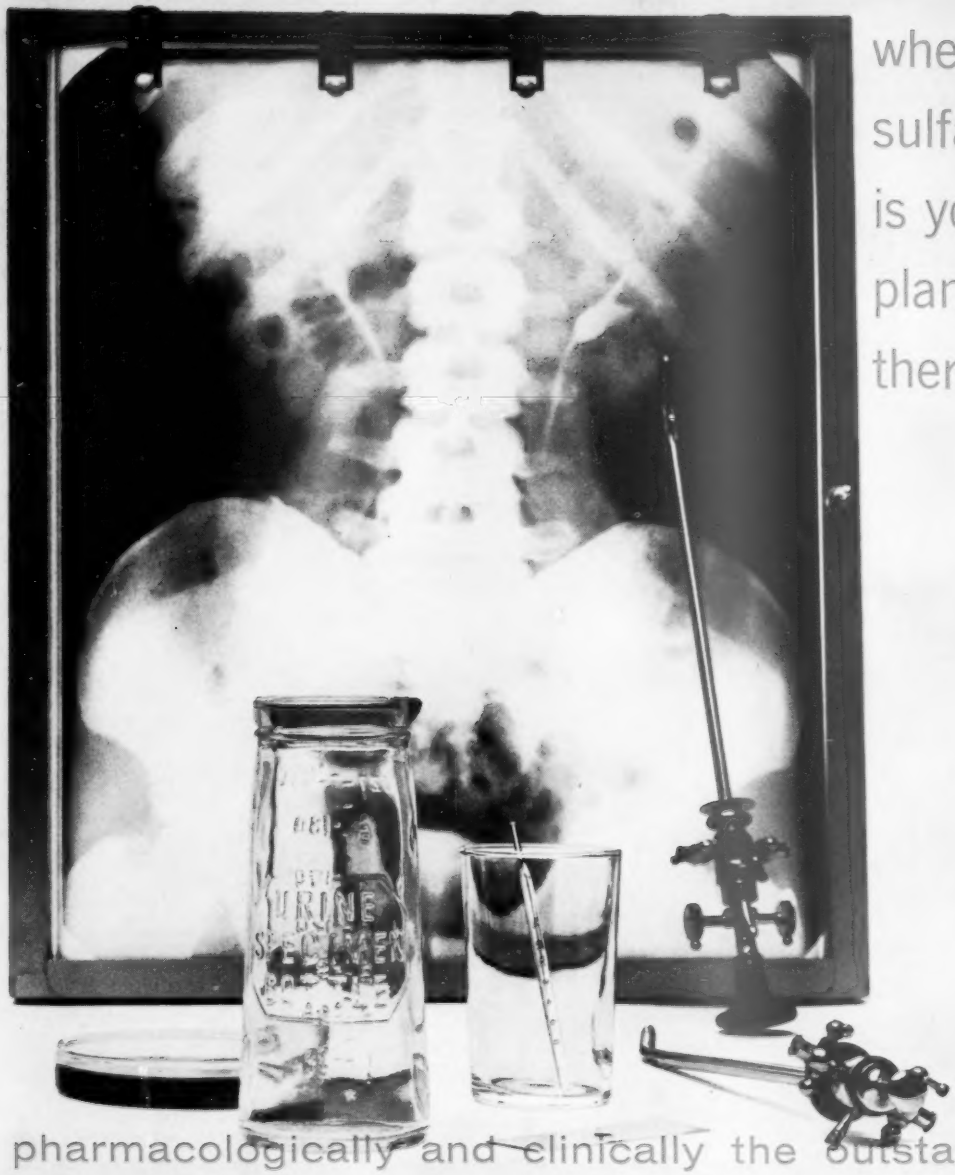
Speaker Covode appointed Drs. Robert E. McCurdy, Thomas H. Mahoney, Jr., and Freeman Longwell as Sergeants-at-Arms. He appointed Drs. J. V. Carris and Terry Gromer to the Reference Committee on Board of Trustees and Executive Office to replace absentees and similarly appointed Dr. William H. Ryder to the Reference Committee on Legislation and Public Relations.

Handbook reports of the following committees were referred to reference committees as listed in the Handbook:

Health Education and School Health,
Library and Medical Literature,
Medical Education and Hospitals,
Medical Student Loan Fund,
Medical Service,
Medicolegal Committee,
Public Health Committee, including mimeographed supplement for its Mental Health Subcommittee,
Public Policy Committee, including a mimeographed supplement for its Subcommittee on Publicity,
Rocky Mountain Medical Conference,
Scientific Program,
Advisory Committee on Workmen's Compensation Affairs,
Advisory Committee to Colorado Association of Medical Assistants,
A.M.E.F. Committee,
Military Affairs Committee,
Representatives to Adult Education Council,
Representatives to State Welfare Department Advisory Committee, including a verbal supplement by Dr. John I. Zarit which was discussed by Drs. I. E. Hendryson, Frank Stander, John B.

continued on page 60

*Dr. McDonald's report separately published. See page 40 of the November, 1960, issue of the Rocky Mountain Medical Journal.



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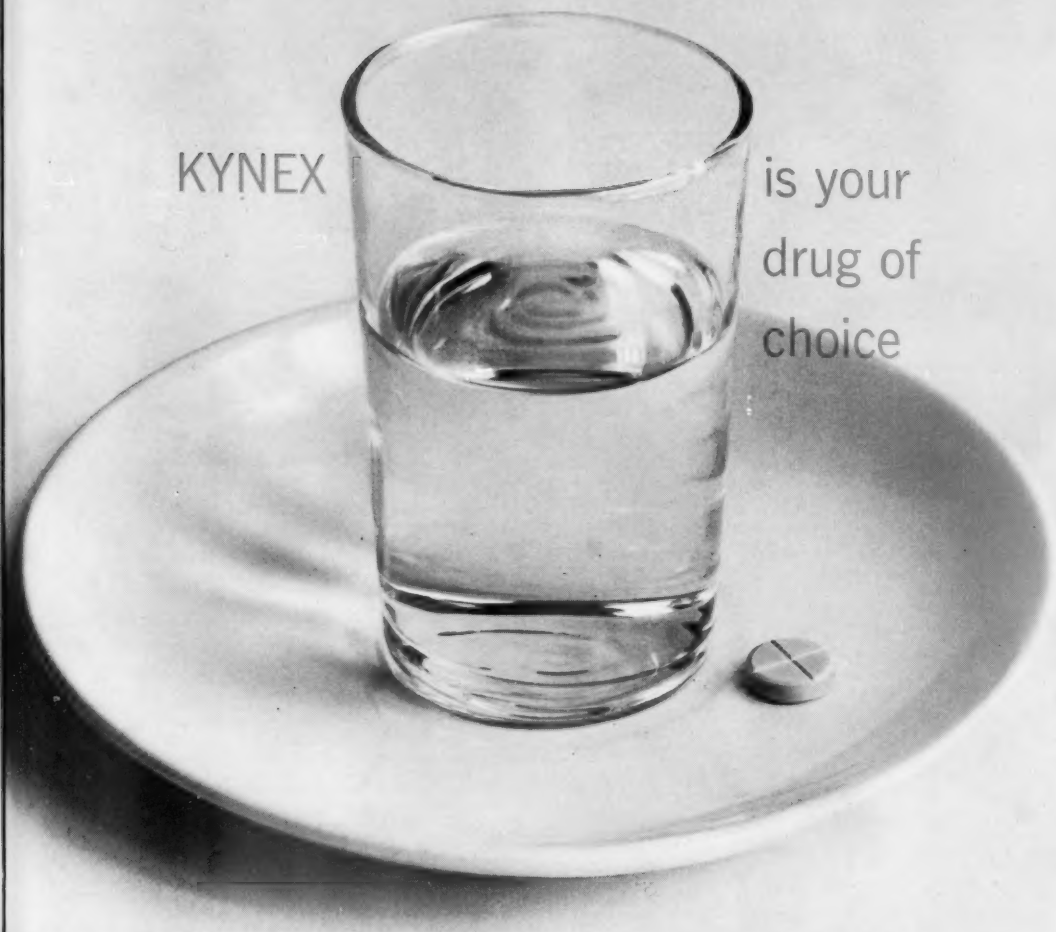
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa...

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

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NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

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Organization cont. from page 57

Farley, and finally by Dr. Zarit.

The following supplement to the report of the Medical Service Committee was submitted by Dr. John B. Grow:

The Service League Community Blood Bank of Pueblo, Colorado, will be nonfunctioning as of March 1, 1961. It has served southeastern Colorado, including Pueblo, La Junta, Rocky Ford, Monte Vista and Alamosa, for seven years. It received its original counseling and advice from the Belle Bonfils Memorial Blood Bank of Denver, Colorado.

The St. Mary-Corwin Hospital and Parkview Hospital, both of Pueblo, will now have self-operating hospital blood banks. This has created the situation whereby the Service League Community Blood Bank cannot operate as a self-supporting, nonprofit organization.

It has been requested by the Service League Community Blood Bank of Pueblo, Colorado, that the Belle Bonfils Memorial Blood Bank, Denver, Colorado, serve the areas of La Junta, Rocky Ford, Monte Vista and Alamosa. The Belle Bonfils Memorial Blood Bank has accepted this responsibility and is offering its services to all areas in Colorado which need its service.

The Public Policy Committee of the Colorado State Medical Society formulated in 1958 a program for the Belle Bonfils Memorial Blood Bank to provide blood service to every area in Colorado requesting it. The Blood Bank is willing to go into all areas and provide blood for them. Such requests have been fulfilled in Fort Collins, Loveland, Longmont and Brighton, Colorado, in 1959 and 1960.

Dr. Thomas H. Mahoney read the following report for the Blue Shield Fee Schedule Advisory Committee which was referred to the Reference Committee on Insurance and Prepayment Plans:

The regular semiannual meeting of the Advisory Committee was held Tuesday evening, September 13, 1960, at the Stanley Hotel.

Pursuant to the House of Delegates' instruction that the committee restudy the assistant surgeon fee problem, a special subcommittee met on June 4th to review the many suggestions received up to that time. These were summarized for consideration by the full committee; consequently, the meeting Tuesday evening was devoted mainly to a review of the entire matter, so that the wishes of all component societies could be heard and evaluated.

After lengthy discussion, it was the consensus that the time spent was probably the most equitable basis on which to determine the payment to be made for assistant surgeon services, and the following allowances were adopted:

Preferred "A": $25 for the first hour; $5 for each additional half-hour.

Preferred: $20 for the first hour; $5 for each additional half-hour.

Standard "A": $15 for the first hour; $5 for each additional half-hour.

The committee agreed, furthermore, that in all cases the time of the assistant surgeon would be less than that of the anesthesia, and in no instance should it be longer. In addition, it was understood that the basic provisions relative to the designation of surgical procedures as eligible for assistant surgeon benefit and the use of interns or residents where present and qualified would be continued.

It is recommended, therefore, that the above method be adopted and referred to the Blue Shield Board of Trustees for their approval.

There were also a number of requests for revisions of fees for certain surgical procedures. These were adopted in the main, with some modifications to conform with the over-all fee schedules of the four Plans. A few requests were denied as actuarily impossible. JOHN H. AMESSE, Chairman.

There were no further annual reports, and the Secretary reported there was no unfinished business.

The first order of new business was the election of a Nominating Committee, and the following Delegates were elected without opposition, by acclamation:

J. Leonard Tillquist, Clear Creek Valley,
Charles G. Freed, Denver,
William S. Abbey, Larimer,
Milton L. Wiggins, El Paso,
Paul B. Stidham, Mesa,
John B. Farley, Pueblo,
Byron A. Yost, Boulder.

Dr. Edward S. Miller addressed the House as follows:

"Mr. Speaker, pursuant to the directive of the House of Delegates at its last Midwinter Session, representatives of the Colorado Medical Service and the Colorado Society of Internal Medicine have met regularly to resolve problems relating to internal medicine. I wish to report that our meetings have been amicable, honest, and forthright. Each side has learned much concerning the problems of the other. Certain general principles have been discussed and agreed upon, and an agenda for systematic approach to our differences has been outlined.

"At the present time, we are exploring a plan which we hope will be mutually acceptable. The details of the plan necessarily require prolonged discussion, which has not as yet been completed. We are therefore unable to report a specific solution at this Annual Meeting. It is hoped that such a report can be presented at the Midwinter Session.

"As a representative of the Colorado Society of Internal Medicine, I wish to thank the Blue Shield representatives for their courtesy, their time and their effort, and their evident good faith."

Dr. Miller's report was referred to the Reference Committee on Insurance and Prepayment Plans.

Dr. William R. Lipscomb addressed the House to urge support of the high school essay contest sponsored annually by the Association of American Physicians and Surgeons. His report was greeted with applause and was referred to the Reference Committee on Legislation and Public Relations.

Dr. Harry C. Hughes, President of Colorado Medical Service, Inc., reported the great growth of Blue Shield in recent years and the importance of its liaison with the Society. His report was referred to the Reference Committee on Insurance and Prepayment Plans.

Dr. S. C. Percefull introduced the following resolution which was referred to the Reference Committee on Insurance and Prepayment Plans:

RESOLUTION

WHEREAS, It appears to the members of the Arapahoe County Medical Society that the large majority of subscribers to the Blue Shield would prefer more adequate fee schedule coverage for services by physicians in the nonsurgical specialties, and

WHEREAS, Internists have withdrawn from membership in the Blue Shield because of inadequate fees provided by the plan, be it

RESOLVED, That the House of Delegates request the Blue Shield and the Blue Shield Fee Schedule Advisory Committee to continue work in the direction of providing adequate fee schedule coverage for medical services by physician members of the Blue Shield, and that the Colorado Society of Internal Medicine be encouraged to rejoin the Blue Shield Plan.

Dr. Harlan E. McClure introduced the following resolution which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The Board of Health and Hospitals of the City and County of Denver and the Mayor of Denver have taken steps to terminate a long-standing, antiquated contract between the City of Denver and the University of Colorado; and

WHEREAS, The Denver General Hospital has organized a new provisional volunteer staff of qualified, licensed members of this Society to help care for the indigent patients of Denver as well as promote graduate training of physicians; and

WHEREAS, The Denver General Hospital will employ a

full-time staff of highly qualified directors in all major medical fields; and

WHEREAS, A nationally recognized consultant has been retained by the City of Denver to assist in the reorganization of the Department of Health and Hospitals as well as to plan the building of a new, modern, and efficient hospital; and

WHEREAS, The Board of Health and Hospitals has invited the University of Colorado School of Medicine to continue to utilize the facilities of the Denver General Hospital for the teaching of medical students and the training of interns and residents; and

WHEREAS, This Society is keenly interested in good patient care, good graduate training, and good medical teaching; therefore, be it

RESOLVED, That the Colorado State Medical Society extend its congratulations to the Board of Health and Hospitals and to the Mayor of Denver for their strong and progressive steps taken to provide qualified full-time department heads to work with qualified, volunteer staff members, widely representative of the community, in a new and more adequate community hospital and thus promote better patient care, better graduate training, and better student teaching to a large and important population segment of our state. We welcome the Denver General to Colorado's ever-growing family of newer and better independent hospitals.

Dr. Charles G. Freed introduced the following resolution on behalf of the Physicians Adoption Committee of Denver, which was referred to the Reference Committee on Miscellaneous Business:

RESOLUTION

The increasing requests for adoption of children, together with tragic situations resultant from placement through channels other than official agencies, call for a real attempt by physicians, in close cooperation wtih legal and social service disciplines, to standardize and elevate the quality of adoptive practices. The medical societies of Utah, Maryland, North Carolina and Ohio have recognized that participation of physicians in direct or unprotected adoptions may constitute an unethical practice as well as jeopardize the welfare of parties in the adoption. Accordingly, they have passed resolutions in support of official agency placement. Also, adoption committees of the American College of Obstetrics and Gynecology, American Academy of Pediatrics, the A.M.A. and the American Academy of General Practice endorse the cooperative participation of the three major disciplines in all adoptions, e.g., medicine, law and social service.

In the best interests of the child, natural parents and adoptive parents and with concern for the implications of unethical practices on the part of physicians participating in independent placements, this committee recommends:

1. Recognition of the unique and vital contributions of, and importance of, cooperation between the three major disciplines involved in adoptions.
2. Discouragement of physicians from participation in any direct or unprotected placement of a child for adoption.
3. Utilization of the services of authorized agencies.

On motion of Dr. John A. Davis, seconded and carried without dissent, the House went into Executive Session where it heard confidential matters. On arising from Executive Session, the Speaker and the Secretary made routine announcements, and the Speaker then declared the House adjourned until 2:30 p.m. on September 15.

SECOND MEETING

Thursday, September 15, 1960

Speaker Covode called the House to order at 2:30 p.m. and following certification of several Alternates to be seated in the absence of their regular Delegates, the roll disclosed 50 accredited members of the House present, more than a quorum. Before adjournment, the roll call totaled 57.

Before opening the House for business, Speaker Covode declared his intention to open the House with an invocation, and expressed the hope that

this would become a custom. Speaker Covode gave the following invocation:

"To the God to whom any man in this audience turns, when he feels that need, we make this appeal: Help us in our deliberations to solve our problems in a fashion acceptable to You. Strengthen us against the temptations of personal gain and factionalism, so that we may be led to wise decisions. Soften our tongues in debate. We thank You for these majestic surroundings in which we hold this meeting, and for the privileges we enjoy individually and as a profession, in this wonderful and free country. Amen."

On motion seconded and carried without dissent, the House dispensed with the reading of the minutes of its first meeting.

President McDonald presented the following report which was referred to the Reference Committee on Insurance and Prepayment Plans:

At the September 14 meeting of the Board of Trustees, it voted to renew the Medicare Contract, effective October 1, on exactly the same terms as the one that will expire the end of this month.

The Board approved the nominations offered by President-elect Anderson for membership on the five administrative councils under the new By-Laws. Thus the Board, agreeing with Dr. Anderson's nominations, has no further nominations of its own to offer at this time.

The Board also received a letter and supporting documents from Dr. Harry C. Hughes as President of our Blue Shield Plan, reiterating a previous request of the joint Policy Committee of Blue Cross and Blue Shield that this Society undertake a new endeavor toward minimizing overutilization of hospital facilities. I will quote the pertinent sentences from that letter:

"The recently announced Blue Cross rate adjustment, made necessary by increased hospital costs, appears to be fairly well understood and consequently accepted by the subscribing public. However, further increases in the Blue Cross costs must be avoided, if at all possible, or we will find this important health protection program priced beyond the reach of the average working family.

". . . It is hoped that the Colorado State Medical Society might offer to join hands with the Colorado Hospital Association in sponsoring the formation of Admission and Discharge Committees in all the hospitals of this state.

"Since the discussion of this subject by the Public Policy Committee, the Pueblo County Medical Society—through its members on the hospital staffs in Pueblo—have established such committees and they are reported to be functioning with reasonable success."

The Chair introduced several special guests of the House, including Dr. Allan L. Haynes, President of the New Mexico Medical Society, Dr. Wesley Hall, President of the Nevada State Medical Association, and Dr. George M. Fister of Ogden, a member of the Board of Trustees of the American Medical Association. Dr. Fister addressed the House briefly with greetings from the A.M.A., and urged more physicians to take part in local, state, and national political activity.

Secretary Sethman read a telegram of greetings to the House from Louis H. Bauer, M.D., Secretary General of the World Medical Association.

Dr. Paul B. Stidham, Chairman, read the following report which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Board of Trustees and Executive Office

Your reference committee recommends approval of the report of the Board of Trustees as carried on pages 17 through 21 of the Handbook and of the supplemental report as carried on page 22.

Your committee recommends approval of the report of the Foundation Advocate as carried on page 25 of the Handbook.

Your committee recommends approval of the report of the Executive Secretary as carried on pages 25 through 31 of the Handbook.

Your committee recommends approval of the supplemental report of the Board of Trustees dated August 31, 1960, as regards payment of Journal income to the Society; the honorarium to speakers at the Society's sessions; the nomination of certificates of service; and the recommendation of the Ad Hoc Committee on Retirement Plan and the report of the Retirement Plan.

The ad hoc committee took into consideration the plan as developed by the Montana State Medical Association (presented to the House by Dr. H. C. Hughes) and rejected it, primarily because of the compulsory aspect of the plan. With this your reference committee is in full agreement.

Your reference committee wishes to thank the Board of Trustees and the Executive Secretary for their hard work during the past year and to compliment them on the retirement plan which has been offered to the members of the Colorado State Medical Society.

PAUL B. STIDHAM, Chairman
F. W. BARROWS — TERRY J. GROMER
S. P. ESPOSITO — HOWARD T. ROBERTSON

Dr. William S. Curtis, Chairman, read the following report of the Reference Committee on Legislation and Public Relations, which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Legislation and Public Relations

Your reference committee has studied the reports of the subcommittees of the Medical Service Committee carried on pages 34, 35, and 36 of your Handbook and has the following comments and recommendations:

Your reference committee recommends approval of the report of the Subcommittee on Blood and Tissue Banks as printed on page 34 of the Handbook and the oral supplemental report read for Dr. Rettberg by Dr. Grow.

Your committee recommends approval of the report of the Subcommittee on Emergency Medical Service as printed on pages 34 and 35 of the Handbook and commends them for their varied and progressive activities.

Your committee received no report from the Subcommittees on Hospital-Professional Relations, Medical Care of Veterans and Physician-Nurse Relationships; therefore recommends approval of the statements printed on pages 35 and 36 under these headings.

Your committee recommends approval of the report of the Subcommittees on Indigent Medical Services, on Prepayment Services and on Professional Insurance as carried on page 36 of the Handbook.

Your committee was given the first paragraph of the report of the Subcommittee on Industrial Health of the Public Health Committee printed on pages 40 and 41 of the Handbook. The recommendation made and the report titled "An Expanded Program in Occupational Health for the State of Colorado Department of Public Health," dated October, 1959, were studied. Your committee felt that, even though the thought contained in the recommendation may be commendable, the information available was too limited to recommend approval. Therefore, your reference committee does not recommend approval of this recommendation.

Your committee studied the report of the Public Policy Committee printed on pages 7-50 of your Handbook. Since it is mainly informational, your reference committee wishes to join the Public Policy Committee in its expressions of appreciation. Your committee commends the Public Policy Committee for its efforts and recommends approval of its report with the following statement: Your reference committee feels the practice of coercing staff doctors in regard to donations for new hospital construction is not healthy and should be opposed.

Your committee recommends approval of the report of the Subcommittee on Publicity printed on page 50 of the Handbook and of the supplemental report distributed to the House and commends Dr. Bouslog and his committee for their continuing fine work.

Your committee recommends approval of the report of the Special Committee of the Advisory Committee on Workmen's Compensation Affairs printed on page 53 of the Handbook and commends them for their method of procedure in regard to the fee schedule.

Your committee recommends approval of the report of the Special Committee of the Representatives to the State Welfare Department Advisory Committee as this is informational (page 54-55), with specific discussion undertaken by another reference committee, and commends the members of

this special committee for its tireless efforts.

The resolutions of Dr. John McDonald and Dr. Harlan McClure were discussed and not approved as such. However, after hearing from numerous interested members of the Colorado State Medical Society, your reference committee makes the following recommendations and statement:

1. That the Colorado State Medical Society reiterate its belief that the State of Colorado does and should have a strong, progressive medical school and that a close liaison between the full-time faculty and the volunteer teaching staff is essential.

2. That the Colorado State Medical Society recognizes Denver General Hospital as an institution dedicated to the care of the medically indigent, to rendering emergency medical service, and to good medical teaching. It commends the Board of Health and Hospitals and the Mayor of Denver for their conscientious efforts in this direction.

Your reference committee, recognizing that there exists agreement for future meetings between the Denver Board of Health and Hospitals and the University of Colorado School of Medicine, sincerely believes that a close working relatio:. ship can be reaffirmed.

Your reference committee wishes to express deep appreciation to Dr. John McDonald for the considerable time and energy spent on these matters; and to thank the many members who appeared before the committee. I wish to further thank the committee members for their diligence.

WILLIAM S. CURTIS, Chairman
MORGAN A. DURHAM — ROBERT E. McCURDY
WILLIAM LIPSCOMB — WILLIAM H. RYDER

Dr. Jackson Sadler, Chairman, read the following report, which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Professional Relations

Your reference committee recommends the approval of the report of the Board of Councilors, as carried on pages 23-24 of the Handbook.

Your committee recommends approval of the report of the Grievance Committee, as printed on page 24 of the Handbook.

Your reference committee recommends the approval of the report of the A.M.A. Delegation, as printed on pages 24-25 of the Handbook and the supplemental report of Dr. Kenneth Sawyer as presented orally to the House of Delegates.

Your committee wishes to commend particularly the diligence of the A.M.A. delegation from our Society.

Your committee recommends approval of the report of the Medicolegal Committee, as printed on pages 36-37 of the Handbook.

Your committee wishes to recommend approval of the report of the Advisory Committee to the Colorado Association of Medical Assistants as printed on page 53 of the Handbook.

JACKSON L. SADLER, Chairman
FRANK E. STANDER — GEORGE R. BUCK
HENRY A. BUCHTEL — A. J. KAUVAR

Dr. Samuel B. Childs, Chairman, presented the following report:

Report of the Reference Committee on Insurance and Prepayment Plans

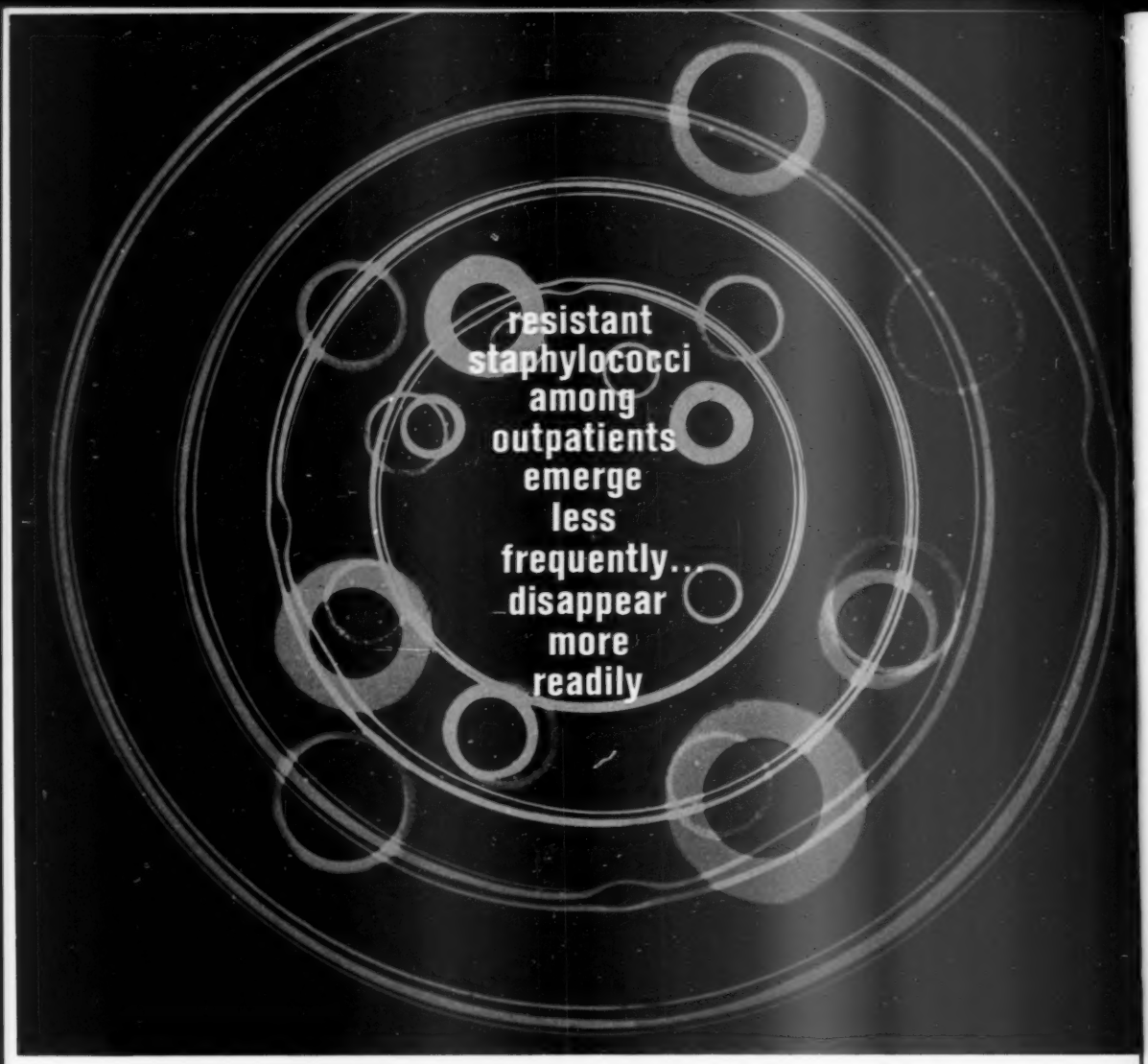
None of the material referred to this committee was carried in the Handbook.

Your committee recommends approval of the report of the Blue Shield Fee Schedule Advisory Committee as read and circularized to the House of Delegates. The part of this report which requires action recommends that the payment to the assistant surgeon for services rendered be for "Preferred A Plan," $25 for the first hour, $5 for each additional half hour; "Preferred Plan," $20 for the first hour, $5 for each additional half hour; for "Standard A Plan," $15 for the first hour, $5 for each additional half hour.

The Blue Shield Fee Schedule Advisory Committee recommends, furthermore, that in all cases the time of the assistant surgeon would be less than that of the anesthesia, and in no instance should it be longer. In addition, it was understood that the basic provisions relative to the designation of surgical procedures as eligible for assistant surgeon benefit and the use of interns or residents where present and qualified would be continued.

It is recommended, therefore, that the above method be adopted and referred to the Blue Shield Board of Trustees for approval.

The report of Edward S. Miller, M.D., representing the



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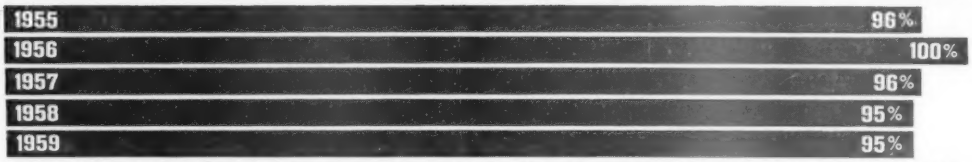

These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. 10360

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Colorado Society of Internal Medicine, is received for information. The committee commends the Colorado Society of Internal Medicine and the Blue Shield for their continuing attempts to discover a plan acceptable both to its members and to the representatives of Colorado Medical Service. Progress has been made, and a satisfactory solution appears forthcoming.

The report of Harry Hughes, M.D., President of the Blue Shield Plan, is received for information. The last paragraph of his report has been referred to another reference committee. The committee commends Dr. Hughes for his report. Continuous liaison between the officers of Blue Shield and the Medical Society circumvents any difficulties which might arise due to lack of information.

The committee acknowledges receipt of the resolution read before the House of Delegates by Dr. S. C. Percefull for the Arapahoe County Medical Society. The committee recommends that no action be taken on this resolution because of the prior reports received from both the Colorado Society of Internal Medicine and the officers of the Colorado Medical Service, which cover its content.

The reference committee acknowledges receipt of the resolution passed by the Advisory Committee to the Division of Medical Services at their meeting of August 10, 1960. This resolution was read to the House by Dr. John Zarit. In addition, this reference committee has considered the remarks made to the House from the floor, which were pertinent to this resolution. It seems necessary, to refresh your memory, to reread this resolution. The resolution states:

"The Medical Advisory Committee feels that all of the current medical services available to recipients of Old Age Pension are essential and have been made a part of the medical program after a careful consideration of all types o medical care needed by the aged. These services were determined on the basis of careful review, and priorities were established in which it was recommended that the most essential type of services be added to the program first.

"We recommend that no curtailment be made in the services until a careful study has been made regarding current utilization and operating procedures, with consideration given to strengthening these procedures and eliminating as much as possible any overutilization. After this review, the State Board will then be in a position to determine if services can be improved within the existing program and can determine what additional monies are necessary to continue current medical services.

"It is recommended that this matter be followed closely every 30 days for the next few months and that, if necessary, the State Board request appropriation of additional funds to finance the program as it is now established."

I move the acceptance of this resolution.

The reference committee proposes that the containment of the Old Age Pension medical plan within an approximation of present fiscal bounds depends upon a discriminate use of the plan.

Entitlement of a subscriber to hospitalization does not of necessity require that a subscriber be hospitalized upon his demand, or for minor complaints, or for diagnostic purposes, or for convenience.

Inspection of the audit of the Old Age Pension Medical Fund expenditures, July 1959-June 1960, reveals that physicians received $1,782,017.69, or roughly 18 per cent of the $10,000,000 spent. Hospitals and nursing homes received $7,852,-168, or 78 per cent of the total spent during the same period. In discussing costs of the OAP fund, the term "medical care" should be amplified for clarity to "hospital and medical care." The projected expenditure for the fund for the year 1960-61, based on monthly expenditures of April, May and June, 1960, totals $11,312,400.00. Due to adoption of Standard "A" Plan for pensioners, physicians' services will total $2,366,400.00, or 21 per cent of the total of the projected expenditure of $11,312,400. The hospitals and nursing homes will receive $8,588,400, or 76 per cent of the total as projected.

Recognizing these factors, the reference committee recommends that the House of Delegates re-emphasize the following points to the State Welfare Department Advisory Committee for transmittal to the Department of Welfare:

1. The doctors have been made aware of their responsibility for prevention of overutilization and will attempt to control this as much as possible.

2. The public at large must be made aware of the fact that the greatest proportion of the OAP sick benefit dollar is spent on hospitalization and convalescent home care, not on doctors' fees.

3. Overutilization of hospitalization is the joint responsibility of the physician and the pensioner. Attempted coercion of doctors by pensioners and their relatives does more to encourage abuse of hospitalization than any other factor. It is incumbent upon the Welfare Department to publicize this fact more thoroughly to the pensioners and their families. This applies equally to admission to the hospital, and to length of stay in the hospital.

SAMUEL B. CHILDS, Chairman

JOHN B. FARLEY	DAVID BATES
H. E. McCLURE	S. E. BLANDFORD
GEORGE CURFMAN	W. S. ABBEY

Following discussion by Dr. H. E. McClure and Dr. Childs, the first section of the report was corrected by the committee to read as reproduced above. This section was further discussed by Drs. L. L. Hick, Jackson L. Sadler, John A. Davis, and Chairman Childs.

After these discussions, the section of the report was adopted as presented and corrected, without dissent.

The last section of Dr. Childs' report was further discussed by Dr. Harry C. Hughes, Mr. J. J. Vance, Executive Vice President of the Blue Shield Plan, and Dr. Bradford Murphey, who moved that the remarks of Mr. Vance be incorporated in the minutes as a part of Dr. Childs' report.

On motion of Dr. John B. Farley, the House went into Executive Session. On arising from Executive Session, the House adopted the action of the Executive Session, tabling the motion made by Dr. Murphey.

All sections of the report of the Reference Committee on Insurance and Prepayment Plans were then adopted without further discussion.

Dr. Alfred Hicks, Chairman, presented the following report which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Scientific Work

Your reference committee recognizes the existence of the Committee on Library and Medical Literature but received no report on which to act.

Your committee recommends approval of the report of the Committee on Medical Education and Hospitals as printed on page 33 and of the inclusive supplemental report previously presented to the Board of Trustees.

Your committee recommends approval of the report of the Subcommittee on Medical Student Loan Fund as printed on page 33. Dr. Reginald Fitz, Chairman of this committee, personally attended our meeting and supplied excellent answers to all inquiries.

Your committee recommends approval of the report of the Committee on Rocky Mountain Medical Conference as carried on page 51 and unanimously favored a vote of thanks to the committees responsible for the success of the meeting.

Your committee recommends approval of the report of the Scientific Program Committee as printed on pages 51-52 and compliments the Program Committee on the current innovation.

ALFRED HICKS, Chairman

HOWARD F. BRAMLEY	STEPHEN B. PHILLIPS
SAM W. DOWNING	T. O. PLUMMER
R. W. LUDWICK	M. L. WIGGINS

Dr. S. C. Percefull, Chairman, presented the following report, which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Public Health

Your reference committee recommends approval of the report of the Health Education and School Health Committee as carried on pages 32-33 of the Handbook and the supplemental report by Dr. Bartholomew urging support of a conference on physicians in schools.

Your committee recommends approval of the report of the Subcommittee on Aging (page 37) and of the written report submitted by Drs. Zarit and Vest and Mr. Derry. The reference committee supports the recommendation of the special

report that the Colorado State Medical Society appoint a staff member to act as medicine's public relations representative to the 1961 White House Conference on Aging.

Your committee recommends approval of the report of the Subcommittee on Alcoholism and Drug Addition as printed on pages 37-38 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Automotive Safety as printed on pages 38, 39, and 40 of the Handbook, and commends it for its efforts.

Your committee recommends approval of the report of the Subcommittee on Cancer as printed on page 40 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Crippled Children as printed on page 40.

Your committee recommends approval of the report of the Subcommittee on Industrial Health as carried on pages 40-41 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Immunization as carried on pages 1-2 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Maternal and Child Health as printed on page 42 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Mental Health as printed on pages 42-46 of the Handbook and the supplemental report, deleting the last sentence of paragraph 2 of page 2 of the supplemental report: "the use of private funds be administrated by the Colorado State Medical Society," and commends the committee for its long hours and hard work.

Your committee recommends approval of the report of the Subcommittee on Rehabilitation as printed on page 46 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Rural Health as printed on pages 46-47 of the Handbook and recommends approval of the Supplemental report from the Chairman of the Rural Health Committee to the Trustees, recommending the establishment of a joint medical and hospital committee to assist outlying hospitals in securing and maintaining accreditation by the Joint Commission. The reference committee recommends that a member of the Colorado Chapter of the American College of Physicians be represented on this committee.

Your committee recommends approval of the report of the Subcommittee on Sanitation as printed on page 47 of the Handbook.

Your committee recommends approval of the report of the Subcommittee on Tuberculosis Control as printed on page 47 of the Handbook.

S. C. PERCEFULL, Chairman
WILLIAM A. DAY GORDON MEIKLEJOHN
BRADFORD MURPHEY

Dr. L. L. Hick, Chairman, presented the following report, which was adopted section by section and as a whole without dissent:

Report of the Reference Committee on Miscellaneous Business

Your reference committee recommends the approval of the report of the A.M.E.F. Committee as carried on pages 53 and 54 of the Handbook.

Your committee recommends approval of the report of the Military Affairs Committee as carried on page 54 of the Handbook.

Your committee recommends approval of the report of the Representatives to the Adult Education Council as carried on page 54 of the Handbook.

Your committee recommends approval of the resolution as introduced by the Physicians' Adoption Committee of Denver on the subject of adoption and read before the House of Delegates. L. L. HICK, Chairman
ROBERT K. BROWN WILLIAM R. SISSON

Dr. John A. Davis, Chairman, presented the following report of the Reference Committee on Constitution, By-Laws and Credentials, which was adopted section by section and as a whole, and in each case by special motions the proposed amendments were adopted and Speaker Covode declared the By-Laws so amended:

Report of the Reference Committee on Constitution, By-Laws and Credentials

Your reference committee recommends approval of the proposed amendments to the By-Laws presented in the initial report of this committee, September 14, 1960. Our recommendations for approval follow: Page 11 of your Handbook, Chapter VI, Section 1, insert the sentence: "The Chairman or Acting Chairman of the Judicial Council and of the Grievance Committee shall be ex-officio members of the Nominating Committee without the right to vote."

Page 14 of the Handbook, Chapter VIII, Section 2, insert, after "shall form the Advisory Committee," this sentence: "The two immediate Past Presidents of the Society may attend the Advisory Committee as ex-officio members without the privilege to vote."

Page 14 of the Handbook, in the same Section 2, insert a period after the word "Society" in the eleventh line and delete the remainder of the paragraph.

Section 4, of Chapter XI, page 34 of the current By-Laws booklet, insert at end of the paragraph the following: "; provided, that physicians in full-time state or federal governmental service of a national or state-wide nature may elect to be members of the component society having jurisdiction over either their residence or the location of their central place of employment."

Your committee recommends approval of the proposed amendments to the By-Laws as presented to the House in the mimeographed supplemental report of the Executive Secretary, with the exception of the proposed amendment to Chapter XI, Section 4, which has been previously recommended in this report.

Your committee recommends approval of the proposed revision of the Standing Rules as presented in the mimeographed supplemental report of the Board of Trustees.

JOHN A. DAVIS, Chairman
H. H. KERR F. ROUKEMA
W. B. CROUCH M. L. CRAWFORD
R. C. BEETHE R. B. RICHARDS

Dr. Charles G. Freed, whom the Nominating Committee had elected as its Chairman, presented the report of the committee, but before doing so moved a special vote of thanks to Dr. Covode as Chairman of the Committee on Scientific Program, for the excellence of the program at this Annual Session. The motion was seconded by several and carried by acclamation. The Nominating Committee report, as follows, was then received and placed on file:

Nomination of Officers

Your Committee on Nominations respectfully offers the following slate of nominations for positions to be filled by election at this 90th Annual Session of the Colorado State Medical Society:

For **President-elect:** Dr. **V. V. Anderson** of Del Norte.

For **Vice President:** Dr. **Sam Downing** of Denver.

For **Constitutional Secretary,** 3-year term: Dr. **Howard T. Robertson** of Denver.

For **Trustee,** 3-year term: Dr. **J. Alan Shand** of La Junta.

For **Councilor, District No. 1,** 3-year term: Dr. **Daniel H. Buchanan** of Denver.

For **Councilor, District No. 4,** 3-year term: Dr. **Lawrence Buchanan** of Wray.

For **Councilor, District No. 5,** 3-year term: Dr. **Lawrence Dickey** of Ft. Collins.

For Members of the Grievance Committee, each for a 2-year term, six to be elected:
Dr. Richard Davis of La Junta,
Dr. Ray Witham of Craig,
Dr. Richard L. Speck of Cortez,
Dr. Joseph Leonard of Lakewood,
Dr. Dwight Dawson of Colorado Springs,
Dr. James Philpott, Jr., of Denver.

For **Delegate to the A.M.A.**, 2-year term (succeeding Dr. K. C. Sawyer): **Dr. K. C. Sawyer** of Denver.

For **Alternate Delegate to the A.M.A.**, 2-year term (succeeding Dr. Gatewood Milligan): **Dr. Gatewood Milligan** of Englewood.

For **Foundation Advocate**: **Dr. W. W. King** of Denver.

For **Speaker of the House of Delegates**: **Dr. Heman Bull** of Grand Junction.

For **Vice Speaker of the House of Delegates**: **Dr. Fredrick Good** of Denver.

For the place of the 94th Annual Session to be held in 1964: Estes Park.*

Speaker Covode stated that the revised By-Laws call at this time for nominations from the incoming President of the Society for vacancies in the Administrative Councils, each member of these Councils to be elected by the House of Delegates. Dr. Cyrus W. Anderson, President-elect, then submitted the following nominations for Administrative Councils and for the Committee on Constitution, By-Laws and Credentials (also subject to House election) and pointed out that in subsequent years only half of each Administrative Council will need to be elected for overlapping two-year terms:

Council on Medical Services
John H. Amesse, Denver, Chairman, 2 years.
Kenneth H. Beebe, Sterling, Vice Chairman, 2 years.
John Zarit, Denver, 1 year.
H. E. Campbell, Denver, 2 years.
Samuel P. Newman, Denver, 1 year.
William A. Liggett, Denver, 1 year.
Vernon L. Bolton, Colorado Springs, 1 year.
Leo J. Nolan, Lakewood, 2 years.

Council on Public Health
Jack D. Bartholomew, Boulder, Chairman, 2 years.
James A. Stapleton, Denver, Vice Chairman, 2 years.
Ward L. Chadwick, Denver, 2 years.
Lewis C. Benesh, Denver, 2 years.
Monroe R. Tyler, Denver, 1 year.
Mariana Gardner, Denver, 1 year.
Franklyn G. Ebaugh, Denver, 1 year.
H. M. VanDerSchouw, Lakewood, 1 year.

Council on Scientific Education
H. Calvin Fisher, Denver, Chairman, 2 years.
G. C. Milligan, Englewood, Vice Chairman, 2 years.
Robert Humphrey, Fort Collins, 2 years.
L. Clark Hepp, Denver, 2 years.
J. Robert Spencer, Denver, 1 year.
Myron C. Waddell, Denver, 1 year.
William M. Covode, Denver, 1 year.
Harold Palmer, Denver, 1 year.

*Changed at final meeting; see page 72.

Council on Government Relations
Bradford Murphey, Denver, Chairman, 1 year.
H. R. Bull, Grand Junction, Vice Chairman, 2 years.
Roland R. Anderson, Colorado Springs, 1 year.
Robert B. Richards, Fort Morgan, 2 years.
K. D. A. Allen, Denver, 1 year.
John Farley, Pueblo, 1 year.
George S. Tyner, Denver, 2 years.
Samuel Haigler, Denver, 2 years.

Council on Professional Relations
Clare C. Wiley, Longmont, Chairman, 2 years.
William Lipscomb, Denver, Vice Chairman, 2 years.
Everett Munro, Grand Junction, 1 year.
Fred R. Harper, Denver, 2 years.
George R. Buck, Denver, 2 years.
John Bouslog, Denver, 1 year.
Eugene Wiege, Greeley, 1 year.
Clyde Stanfield, Denver, 1 year.

Committee on Constitution, By-Laws and Credentials
H. Harper Kerr, Pueblo, Chairman.
John A. Davis, Arapahoe.
W. B. Crouch, El Paso.
Robert McCurdy, Denver.
Leonard Tillquist, Clear Creek Valley.
Richard B. Foe, Weld.
Herman C. Graves, Mesa.
Harlan McClure, Prowers.

Speaker Covode pointed out that the Board of Trustees is privileged to make additional nominations for the Administrative Councils, and called upon President McDonald, Chairman of the Board, who stated that the Board endorsed Dr. Anderson's nominees and had no further nominations to make.

There was no unfinished business and no Delegate presented new business.

Speaker Covode called attention to the fact that the House had completed enough of its business that the optional meeting tentatively scheduled for September 16 could be cancelled, if the House desired. On motion duly made, seconded and carried, this procedure was ordered, and following routine announcements, the Chair declared the House adjourned until 8:00 a.m., September 17.

FINAL MEETING

Saturday, September 17, 1960

Speaker Covode called the House to order at 8:00 a.m., and following a delay to attain a quorum the roll call ultimately disclosed 33 accredited members of the House present, one more than a quorum.

On motion the House dispensed with reading the minutes of the September 15 meeting and proceeded to the election of officers. cont. on page 72

In over five years

Proven
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Effective
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Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

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Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

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Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

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BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

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Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

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Organization cont. from page 67

At the request of the Speaker, Secretary Sethman reread the report of the Nominating Committee. Upon inquiries by Speaker Covode in each case, there were no nominations from the floor for any office, and upon motions duly made, seconded and carried without dissent in each case, each nominee of the Nominating Committee was elected to the designated office by acclamation. (See list, pages 66-67.)

Dr. Charles G. Freed, Chairman of the Nominating Committee, moved that that portion of the Nominating Committee's report recommending that the 1964 Session be held in Estes Park be referred to the Board of Trustees for further study. The motion was seconded and carried without dissent.

The Secretary then reread the list of nominations for Administrative Councils and for the Committee on Constitution, By-Laws and Credentials, as presented at the previous meeting by President-elect Cyrus W. Anderson. On inquiry by the Chair in each case there were no further nominations for any of these offices. The Speaker then declared the nominations closed, and there being only one nominee for each office, on motion the nominees presented by President-elect Cyrus W. Anderson were elected by acclamation.

Secretary Sethman presented a verbal supplemental report. He expressed regret that the need for amendment of the nomenclature in the Standing Rule of the House of Delegates relating to appointment of Reference Committees to comply with the revised By-Laws had not been called to the attention of the Reference Committee. He pointed out that the existing nomenclature refers to standing committees of the Society which have now been replaced by Administrative Councils, and will be in error unless corrected at this time. He suggested that the House might wish to authorize appropriate revision of that Standing Rule under direction of the Board of Trustees, without changing the intent of any part of the rule. Upon motion duly made, seconded and carried, the requested authorization was granted by the House.

Vice Speaker Bull asked Past Presidents Gatewood C. Milligan and John Zarit to escort Dr. Vetalis V. Anderson to the rostrum and present him to the House of Delegates. Dr. V. V. Anderson addressed the House as follows:

"Thank you very much. I very deeply appreciate this honor. I will do the very best that I can. I have been interested in the goings-on of the Colorado State Medical Society for a long time. I will do my best this year to become more acquainted with it through my association with the Board of Trustees.

"President Anderson, I appreciate this very much, and to me it illustrates the democracy of this Society. I know in my own mind that Del Norte is the hub of the universe, the garden spot of America, but I would guess that 50 per cent of the doctors in this room have only a faint idea of where Del Norte is; and when a doctor from Del Norte can be elected President-elect, I think that is something. I will do my very best to justify the honor you have given me. Thank you." (Applause)

Dr. George H. Curfman presented the following supplemental report for the Reference Committee on Insurance and Prepayment Plans, which was adopted on motion as a whole without dissent:

Supplemental Report of the Reference Committee on Insurance and Prepayment Plans

The Reference Committee on Insurance and Prepayment Plans has reviewed that portion of the supplemental report of the Board of Trustees to the House of Delegates relative to a letter and supporting documents submitted by Dr. Harry C. Hughes, President of the Blue Shield Plan. Dr. Hughes' letter was accompanied by a suggested method for securing more efficient use of hospital beds in Colorado prepared and recommended by the Joint Policy Committee of Blue Cross-Blue Shield. Basically this method consists of the formation of admission and discharge evaluation committees by individual hospital staffs. Your reference committee recommends approval in principle of the formation of such evaluation committees and further recommends referral of this matter to the Administrative Council on Medical Service, for implementation.

SAMUEL B. CHILDS, Chairman
WILLIAM S. ABBEY — GEORGE CURFMAN
DAVID BATES — JOHN B. FARLEY
SIDNEY E. BLANDFORD — HARLAN E. McCLURE

There was no unfinished business, no Delegate offered any new business, and upon inquiry by the Speaker, Secretary Sethman certified that his official desk was cleared. The House thereupon adjourned without day at 9:20 a.m., September 17, 1960.

The above abstract of minutes is respectfully submitted to the Society.

HARVEY T. SETHMAN,
Secretary, House of Delegates

Obituaries

Weld County loses its past president

Theodore E. Heinz, M.D., died on October 2, 1960, in Greeley. Dr. Heinz was born at Sutton, Nebraska, on December 12, 1898, and attended public schools at Lincoln, Nebraska. He received his B.S. degree from the University of Nebraska in 1926 and was graduated from the University of Nebraska School of Medicine in 1928. He took his internship at Billings Hospital in Chicago and became a fellow in the Department of Medicine there. Further training at the Mayo Clinic in 1930 with emphasis on gastro-enterology and x-ray was taken and later he took advanced studies at the University of Chicago Department of X-ray.

In 1933, Dr. Heinz went to Europe to study as an exchange student from the University of Chicago and he continued to study in his specialty in Vienna, Berlin, and Dortmund, Germany. He then became assistant professor of internal medicine at the University of Chicago. Since November, 1936, Dr. Heinz had been associated with the Greeley Clinic as an internist and head of the Department of X-ray.

He served in both World Wars I and II. During the latter, he was a major in the Army Medical Corps, serving 44 months of active duty.

Dr. Heinz was a member of the Weld County Medical Society and served as its President in 1941. He was also a member of the Colorado So-

ciety of Internal Medicine. He found time to be an associate member of the faculty at Colorado State College and served as one of the physicians in the Student Health Department. He was a charter member and served two terms as President of the Greeley Knife and Fork Club as well as past President and honorary life member of the Greeley Lions Club.

More and more varied were his interests. As a physician for Camp Bob Wait, Boy Scout Camp, he will always be remembered. As a member of the Board of Directors of the Greeley Concert Association and as a member of the Greeley Philharmonic Orchestra, playing the violin, he will also be remembered. A 32nd degree Mason, Knight Templar, Shriner and especially as the past Rainbow Dad and a member of the Board of the Order of Rainbow for Girls, Greeley will never forget him. Last June, he was given the Grand Cross of Color, the highest award of Rainbow, at the Grand Assembly at Sterling.

Dr. Heinz and his family have given 10 scholarships to college to worthy students and Dr. Heinz took special interest in the careers of the recipients. Survivors include his wife and son.

Noted Denver internist dies

Allen David Riemer, M.D., died recently in Los Angeles, California. Dr. Riemer was born on April 6, 1910, in Manchester, England, and received his Bachelor of Arts degree at Harvard in 1932. He graduated from Johns Hopkins in 1936 as a Doctor of Medicine and interned at Denver General Hospital and later at St. Anthony Hospital. He was a resident at Johns Hopkins in medicine. He was licensed in Maryland and in Colorado in 1939.

Dr. Riemer was a member of the Denver Medical Society and limited his work to internal medicine. He was on the staff of General Rose and St. Anthony Hospitals.

Dr. Riemer was one of the first internists who recognized the use of steroids in heart disease and his exhibits were shown at many state and national meetings.

Survivors are his wife and two children.

(left) Raymond F. Peterson, M.D., President Montana Medical Association and Albert L. Vadheim, Jr., M.D., Assistant Secretary-Treasurer.

(left to right) Everett H. Lindstrom, M.D., President-Elect; Leonard W. Brewer, M.D., Immediate Past-President; S. C. Pratt, M. D., Alternate Delegate to the A.M.A.; and William E. Harris, M.D., Secretary-Treasurer.

Montana President resigns

(The following was taken from Dr. Raymond F. Peterson's letter which appeared in the Montana Medical Association's November Bulletin.)

"I want to express my deepest appreciation to the members of the Montana Medical Association for having chosen me for the highest honor that Montana medicine can bestow, that of President of the Montana Medical Association. This to me is especially significant at this time because as you know I will leave the state and the people in it whom I love so much about November 1. . . . Raymond F. Peterson, M.D."

We are sure all Montana physicians sincerely regret that unforeseen and unpredictable circumstances have made it necessary that Dr. Peterson move to California so soon after his installation as President of the Association. Dr. Peterson has served organized medicine in Montana actively and enthusiastically for nearly 15 years and during this period has made significant contributions to the effectiveness of the Association and to the health of Montana citizens. It is, we believe, unfortunate that Dr. Peterson will be unable to fulfill his duties as President.

On behalf of all Montana physicians, we extend our highest commendations to Dr. Peterson and our very best wishes for his continued success and happiness in his new association. His new address will be: 801 Laguna Road, Sunny Hills, Fullerton, California.

WYOMING

Abstract of House Proceedings* Wyoming State Medical Society

Fifty-Seventh Annual Meeting
September 7, 8, 9, 10, 1960
Jackson Lake Lodge, Moran, Wyoming

FIRST SESSION
Wednesday, September 7, 1960

The business session of the House of Delegates, 57th Annual Meeting of The Wyoming State Medical Society, was called to order at 9:20 o'clock, a.m., September 7, 1960, by President Benjamin Gitlitz.

Dr. Frederick H. Haigler of the Credentials Committee called the roll and it was determined that a quorum was present. Dr. Bernard J. Sullivan moved that the minutes of the 1959 annual meeting as printed in the Delegates' Packet be approved. Seconded by Dr. R. W. Holmes. Motion carried.

Old business

Under old business, after discussing the Public Relations Program briefly, Dr. Benjamin Gitlitz called on Dr. Francis Barrett, Chairman. Dr. Barrett referred to his report in the Delegates' Packet and discussed the possibility of engaging a public relations consultant and stated that several other states that had such a program, as well as the A.M.A., recommended that Wyoming do the same. He stated that he had contacted a public relations firm in Cheyenne and that they had agreed to a fee of $100 per month in the event that the Society desired to proceed with such a program for a year. Dr. John H. Froyd moved that up to $100 per month be allowed for public relations. Seconded by Dr. H. B. Anderson. Dr. Howard P. Greaves suggested that the motion include the provision that this program be limited to one year. With the permission of the second, Dr. H. B. Anderson, Dr. John H. Froyd withdrew his motion and moved that the society be authorized to spend up to $100 per month for one year for the purposes of securing a public relations consultant. Seconded by Dr. H. B. Anderson. Motion carried.

Dr. Benjamin Gitlitz called for a report of the Scholarship Committee. He stated that the Council felt that the Scholarship Committee should

*These minutes represent actions taken largely on material from the official packet of the Wyoming State Medical Society. This packet contains the reports that are representative of committee activities and recommendations and form an official part of these minutes.

have the use of a $5,000 fund. Dr. Bernard J. Sullivan discussed the program briefly and suggested that the recipients of loans should pay a nominal interest rate. Dr. R. W. Holmes spoke on the manner of handling such a fund in the light of safeguards for all members of the Society, as well as those comprising the House of Delegates. Dr. Dan B. Greer described the program planned in Laramie County. After extensive discussion it was moved by Dr. Paul J. Preston that the House of Delegates authorize that $5,000 be placed in the Scholarship Loan Fund to be used at the discretion of the committee, pending approval of their plan of operation by the Council. Seconded by Dr. Dan B. Greer. Motion carried.

Dr. Gitlitz discussed, under old business, the coalition of volunteer agencies, but that there was neither a written report nor an oral report.

Dr. R. W. Holmes stated that he would prefer to delay his report of the Wyoming Tuberculosis Committee until Friday afternoon.

Dr. Benjamin Gitlitz called upon the members of the House of Delegates to present all resolutions to Dr. Francis Barrett before noon in order that he could meet with his committee and recommend action on Friday.

It was moved by Dr. Bernard J. Sullivan and seconded by Dr. R. W. Holmes that the Treasurer's report, as published in the Delegates' Packet, be approved. Motion carried.

Dr. Frederick H. Haigler stated that there was no Secretary's report.

Report of A.M.A. Delegate

Dr. A. T. Sudman stated that as Delegate to the A.M.A. he had no printed report, but reporting orally, said that the last two meetings had been two of the least controversial meetings that he had attended. He stated that the A.M.A. is taking a firm stand in all their policies when they are called to testify before various government agencies to leave it up to the individual to have free choice of physician. He also discussed health care for the aged, the cost of drugs, occupational health programs, Social Security and medical examination to pilots. It was moved by Dr. Bernard J. Sullivan and seconded by Dr. Charles W. Jeffrey that the report be approved. Motion carried.

Dr. Bernard J. Sullivan discussed the procedure followed at the A.M.A. meetings and urged all doctors who were interested in action on a national level to attend the A.M.A. and to attend the scientific exhibits.

After supplementing the written report in the Packet with oral remarks, it was moved by Dr. H. B. Anderson and seconded by Dr. Gerald R. Smith that the report of the Executive Secretary be approved. Motion carried.

Dr. Benjamin Gitlitz gave a report of the Council's meetings and the action taken during the past year. Following discussion, the following budget was unanimously adopted:

Travel—Executive Secretary and others	$ 1,000.00
Travel—A.M.A. Delegate and Alternate	1,000.00
Salary—Executive Secretary	2,500.00
Office Expense—Executive Secretary	1,000.00
Rocky Mountain Medical Journal	650.00
Printing, Stationery, Supplies	500.00
Woman's Auxiliary	400.00
Postage	600.00
Public Relations and Advertising	1,200.00
Committees and Conferences (not State meeting)	585.00
Telephone and Telegraph	250.00
Auditing	70.00
President's Office	250.00
Secretary's Office Treas.	100.00
Legal	1,800.00
A.A.P.S. Prizes	100.00
Surety Bonds	50.00
Dues and Subscriptions	120.00
Miscellaneous	250.00
Transcription of State Minutes	225.00
Wyoming-Colorado Science Fair	100.00
Total	$12,750.00

A copy of his written report is attached to the original minutes. It was moved by Dr. Silvio J. Giovale that the report be approved. Seconded by Dr. R. W. Holmes. Motion carried.

Mr. Arthur R. Abbey discussed the time and place of the next annual meeting. No action was taken and the matter was tabled until the next session of the House of Delegates on Friday, September 9.

Reports of committees

Dr. Norman R. Black was called upon to report for the Public Policy and Legislative Committee. Dr. Black stated that on Page 67 of the Packet there was a short report. A supplemental written

report of the Joint Committee of Physicians and Attorneys was then read, which written report, containing a copy of the proposed legislation, is attached to the original minutes. The matter was then discussed by Mr. Byron Hirst, legal advisor to the Wyoming State Medical Society. The proposed bill under discussion provides for witness fees for expert witnesses of $25.00 per day. It was moved by Dr. Dan B. Greer that the report be approved and the bill presented to the Legislature. Seconded by Dr. Paul J. Preston. Motion carried.

Dr. Benjamin Gitlitz reported for the A.M.E.F. Committee and discussed the contributions list published in the Delegates' Packet. Dr. Bernard J. Sullivan explained that the $5.00 contributions were memorial contributions, in lieu of flowers. Dr. Silvio J. Giovale questioned the advisability of publishing such a list and the amounts of the contributions. It was suggested that the A.M.E.F. Committee should decide whether or not to publish such a list in the future.

Reporting for the Auditing Committee, Dr. James W. Barber stated that the report was in the Delegates' Packet, and suggested that this committee was a good example of a committee that could be abolished, and suggested that the work be transferred to trained auditors for the Society. Dr. Barber moved that such action be taken. Seconded by Dr. R. W. Holmes. Motion carried.

Dr. Frederick H. Haigler stated that the Blue Cross Committee report was in the Packet. In addition, he discussed unnecessary hospitalization under Blue Cross. Dr. Francis Barrett stated that he had a resolution on that point which would be presented to the House of Delegates. Dr. R. W. Holmes moved that the report be approved. Seconded by Dr. H. B. Anderson. Motion carried.

It was moved by Dr. John H. Froyd that the report of the Blue Shield Committee as printed in the Packet be approved. Seconded by Dr. Silvio J. Giovale. Motion carried.

There was no one present to report for the Constitution and By-laws Committee and Dr. Gitlitz stated that Johnson County had requested recognition as an individual county and that its constitution and by-laws are being studied by Dr. Barrett and Mr. Hirst and they will present the resolution to recognize them on Friday, September 9.

Dr. Benjamin Gitlitz brought up the matter of the incorporation of the Wyoming State Medical Society as a nonprofit corporation and asked approval of the House of Delegates of such action. Dr. Silvio J. Giovale moved that the incorporation of the Society as a nonprofit corporation be approved. Seconded by Dr. Dan B. Greer. Motion carried. (Articles of Incorporation are filed with the original minutes.)

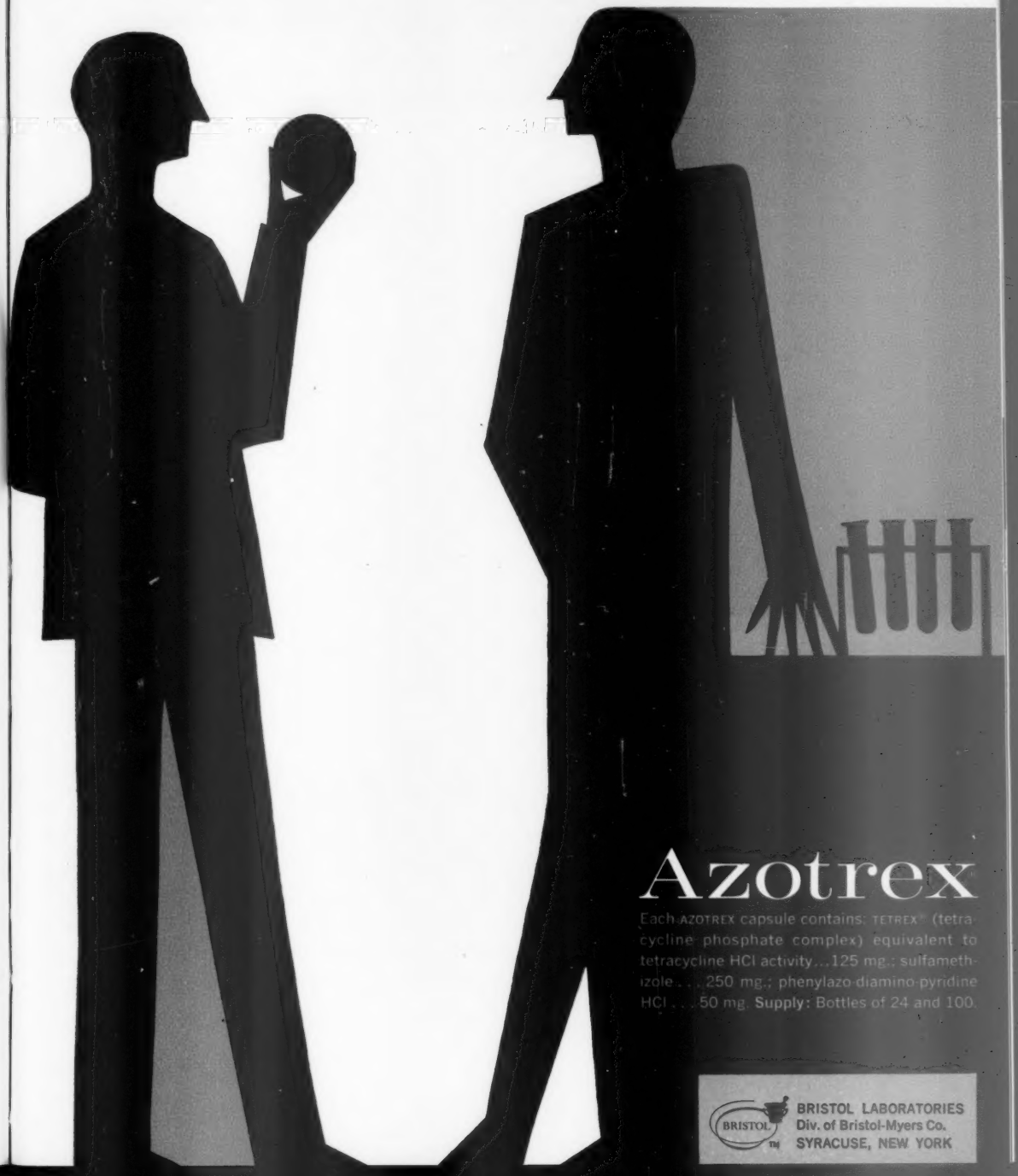
Dr. John R. Bunch asked for an expression from the House of Delegates whether or not the Fee Schedule Committee should attempt to notify doctors in the state what charges are being made for house calls, and so on, other than the stated fees that are in the Blue Cross schedule. Dr. H. B. Anderson stated that such a schedule may be contrary to the provisions of the A.M.A. and, before any action be taken, that the matter should be studied further. No action was taken.

Dr. James W. Sampson was not present, but his report on the Gottsche Advisory Committee was printed in the Packet and in such report he moved that the committee be abandoned. However, Dr. Gitlitz stated that Dr. Sampson suggested that there be a Gottsche Committee. No action was taken.

Dr. Gitlitz stated that Dr. J. S. Hellewell, Chair-

"Well, I'll send the culture to the lab, and we should hear from Bacteriology in a day or two. Now, how shall we treat her cystitis while we're waiting?"

"The chief usually orders AZOTREX. *The azo dye is an excellent urinary analgesic and the sulfamethizole and tetracycline are likely to take care of most of the bugs you find in the urinary tract. If necessary, you can switch to something else after you get the lab findings. But it probably won't be necessary."*



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man of the Grievance Committee, has requested that his term be discontinued and that he was resigning, that he felt that he had served his time. Dr. Gitlitz stated that it would be up to Dr. Barrett to appoint a new member. Dr. Paul J. Preston moved that the report as published in the Packet be approved. Seconded by Dr. John R. Bunch. Motion carried.

It was moved by Dr. James W. Barber and seconded by Dr. Silvio J. Giovale that the report of the Committee on Judicial and Advisory to Workmen's Compensation as printed in the Packet be approved. Motion carried.

Dr. E. Chester Ridgway moved and Dr. Dean A. Holt seconded that the report of the Maternal Welfare Committee as published in the Packet be approved. Motion carried.

Dr. Mark Farrell, Jr., discussed his report for the Mental Health Committee as set out in the Delegates' Packet, together with mental health problems throughout the State of Wyoming.

Dr. Carleton D. Anton was called upon to report for the Necrology Committee. Dr. Anton reported that Wyoming physicians deceased since the last meeting of the Wyoming State Medical Society were:

Dr. Winifred Ingersoll, 70, died July 31, 1960.

Dr. H. L. Goff, Cheyenne, 81, died May 8, 1959.

Dr. Phillip S. Pauling, Rock Springs, died May 27, 1959.

Dr. Ernest A. Kahn, Cheyenne, 50, died January 21, 1960.

Dr. James V. Carter, San Francisco, 33, died January 23, 1960.

Dr. Chester A. Conyers, Cheyenne, 78, died February 8, 1960.

Dr. Edward S. Lauzer, Cora, 78, died May 1, 1960.

The House of Delegates then stood for a moment of silent tribute.

Dr. John R. Bunch moved that the families of the deceased doctors be notified of the action of the House of Delegates in paying tribute to them. Seconded by Dr. R. I. Williams. Motion carried.

Dr. Benjamin Gitlitz then read a letter from Dr. Silvio J. Giovale, advising of his withdrawal from consideration as a candidate for President-elect.

Dr. Paul J. Preston, reporting on the activities of the Poliomyelitis Committee, stated that this was one of those committees that could well be discontinued. Dr. Dan B. Greer moved that the recommendation be followed. Seconded by Dr. Silvio J. Giovale. Motion carried.

Reporting for the Radiation Problems Committee, Dr. James W. Barber stated that the report in the Packet was a preliminary report, the first one the committee had made, and discussed the report briefly. Dr. Silvio J. Giovale moved that the report as printed in the Packet be approved. Seconded by Dr. E. Chester Ridgway. Motion carried.

Dr. H. B. Anderson presented a written report for the Research Committee, a copy of which was handed to each Delegate. It was moved by Dr. James W. Barber and seconded by Dr. Silvio J. Giovale that the report be approved. Motion carried. The House of Delegates applauded the fine report and the efforts of Dr. Francis Barrett and the committee on its preparation. Mr. Arthur R. Abbey stated that Dr. Anderson was the guest speaker at the National Blue Shield conference in Los Angeles and that he did a magnificent job.

Dr. Benjamin Gitlitz read a telegram directed to Dr. W. Andrew Bunten by Dr. Louis H. Bauer, Secretary General, which telegram is attached to the original minutes.

Whereupon the House of Delegates was recessed at 12:30 p.m., September 7, 1960, to 2:00 p.m., September 9, 1960.

SECOND SESSION

Friday, September 9, 1960

The final session of the House of Delegates was called to order by President Benjamin Gitlitz at 2:10 p.m., Friday, September 9.

It was moved by Dr. Silvio J. Giovale and seconded by Dr. Dan B. Greer that the report of the Rheumatic Fever Committee be approved as

printed in the Delegates' Packet. Motion carried.

Dr. Silvio J. Giovale moved and Dr. Dan B. Greer seconded that the report as published in the Packet for the Committee on the Rocky Mountain Medical Conference be approved. Motion carried.

Mr. Arthur R. Abbey read the report of the Managing Editor of the Rocky Mountain Medical Journal prepared by Mr. Harvey T. Sethman, Executive Secretary of the Colorado State Medical Society, which report is attached to the original minutes.

Dr. Benjamin Gitlitz then presented Mrs. O. C. Reed of Torrington, Wyoming, President of the Woman's Auxiliary to the Wyoming State Medical Society, who spoke briefly to the House of Delegates, discussing the activities of the Auxiliary, and then introduced Mrs. William Mackersie of Detroit, Michigan, President of the Woman's Auxiliary to the A.M.A. Mrs. Mackersie addressed the House of Delegates and reaffirmed the dedication of the Auxiliary to be of assistance to the medical profession. The House of Delegates then applauded the recognition of this body by the Presidents of the State and National Auxiliaries.

It was moved by Dr. Dan B. Greer and seconded by Dr. Paul J. Preston that the report of Mr. Harvey T. Sethman be approved. Motion carried.

Dr. Francis Barrett, reporting for the Resolutions Committee, presented the following:

Resolutions

RESOLVED, That the Wyoming State Medical Society welcome the Johnson County Medical Society to full membership in the Wyoming State Medical Society.

The Resolutions Committee recommended that the resolution be accepted. Seconded by Dr. Raymond E. Kunkel. Motion carried. (Copy of the Constitution and By-laws are attached to the original minutes.)

RESOLVED, That the Wyoming State Medical Society shall sponsor a postgraduate seminar on Teenage Guidance and Counseling Techniques and authorizes up to $500 for expenses.

The Resolutions Committee recommended that the resolution do pass. It was moved by Dr. John H. Froyd and seconded by Dr. Oliver K. Scott that the resolution be passed. Motion carried.

RESOLVED, That the Wyoming State Medical Society shall investigate the various causes of overutilization of Blue Cross in Wyoming.

The Resolutions Committee recommended that the resolution do pass. It was moved by Dr. Raymond E. Kunkel and seconded by Dr. John H. Froyd that the resolution be approved. Motion carried.

RESOLVED, That the Wyoming State Medical Society endorse the efforts of the Division of Mental Health of the Wyoming State Health Department and allied groups in their study and investigation of the medical legal problems surrounding mental illness.

Dr. Barrett stated that the Mental Health Committee, headed by Dr. Mark P. Farrell, had presented the resolution and the Resolution Committee asked the passage of the resolution. Dr. R. W. Holmes moved that the resolution do pass. Seconded by Dr. Dan B. Greer. Motion carried.

RESOLVED, That the Wyoming State Medical Society oppose the incarceration of mentally ill patients in jail while awaiting psychiatric evaluation.

The resolution was approved.

RESOLVED, That the immediate Past President of the Wyoming State Medical Society shall assume full Council membership during the year following his term of office.

The Resolutions Committee recommended that the resolution do pass. Dr. E. Chester Ridgway moved that the resolution be passed. Seconded by Dr. H. B. Anderson. Motion carried.

RESOLVED, That the Wyoming State Medical Society endorse the principle of the Cancer Coordinating Committee and instructs the Council to establish the proper role of the Society in the function of this committee.

It was moved by Dr. John H. Froyd and seconded by Dr. Paul J. Preston that the resolution pass. Motion carried.

RESOLVED, That the By-laws be amended by adding the following:

1. "The Corporation shall not invest or reinvest its funds in shares of stock of corporations unless and until this By-law shall be amended."

2. "The Corporation shall indemnify every officer or director or delegate or councilor, his heirs, executors and administrators, against expenses reasonably incurred or liability incurred by him in connection with any action, suit or proceeding to which he may be made a party by reason of his being or having been a director or officer or delegate or councilor of the corporation, except in relation to matters as to which he shall be finally adjudged in such action, suit or proceeding to be liable for fraud or misconduct; in the event of a settlement before or after action or suit, indemnification shall be provided only in connection with such matters covered by the settlement as to which the corporation is advised by counsel that the person to be indemnified was not guilty of such fraud or misconduct. The foregoing right of indemnification shall not exclude other rights to which he may be entitled."

3. "Wherever used in this Constitution or in the By-laws of Wyoming State Medical Society, the word 'physician' means a doctor having a degree of Bachelor of Medicine or Doctor of Medicine granted by a medical school accredited by the American Medical Association at the time of conferring of the degree."

The Resolutions Committee recommended that the resolution do pass. The motion was made, seconded and the resolution was approved.

WHEREAS, The Wyoming State Medical Society in its Fifty-Seventh Annual Meeting assembled at Jackson Lake Lodge, Wyoming, on September 7, 8, 9 and 10, 1960, has enjoyed a most successful convention; and

WHEREAS, The Scientific Program has been of very high quality with outstanding speakers and several worthwhile exhibits; and

WHEREAS, The hospitality of the personnel of the Jackson Lake Lodge has been shown in many ways, adding to the comfort and enjoyment of all the members and guests; and

WHEREAS, The commercial exhibitors have contributed very materially to the success of the convention by their cooperation and devotion to the needs of the doctors; and

WHEREAS, Special recognition is due President Benjamin Gitlitz for the many ways his leadership and efforts have insured the success of the meeting; and

WHEREAS, Special recognition is due Arthur R. Abbey, Executive Secretary, for his attention to details, efficiency and customary good will; and

WHEREAS, The Wyoming Division of the American Cancer Society, the Easter Seal Program, the American Academy of General Practice and WICHE, have made excellent contributions to the meetings by providing speakers; and

WHEREAS, Many of the officers and committee members of the Society have worked with diligence and devotion throughout the year to make possible the considerable achievements of the Society; and

WHEREAS, Our Society has been additionally honored by the delegation from Colorado, including Dr. McDonald, the President of the Colorado State Medical Society; and

WHEREAS, The success and the charm of the convention is greatly enhanced by the presence and valued loyalty of the Ladies' Auxiliary; therefore, be it

RESOLVED, That the members of the House of Delegates of the Wyoming State Medical Society assembled take this opportunity to unanimously express their deep appreciation for all of the matters heretofore contained.

The resolution was approved by unanimous acclaim.

It was moved by Dr. Silvio J. Giovale and seconded by Dr. Paul J. Preston that the report of the Rural Health Committee as published in the Packet be approved. Motion carried.

It was moved by Dr. R. W. Holmes and seconded by Dr. Raymond E. Kunkel that the report of the State Institutions Advisory Committee as printed in the Delegates' Packet be approved. Motion carried.

Dr. R. W. Holmes reported orally for the Wyoming Tuberculosis Problems Committee. He stated that the plan of the committee had been previously reported. He stated that the State Board of Charities and Reform did not see fit to follow the plan previously provided by the same board, and to work through the State Department of Public Health. Dr. Francis Barrett moved that the report of Dr. Holmes be approved. Seconded by Dr. Silvio J. Giovale. Motion carried.

Dr. Benjamin Gitlitz stated that Hoffman LaRoche wanted the names of two pioneer doctors to be honored, and the Society submitted the name of Dr. George Johnston, who held the Number One license in Wyoming.

Dr. Cecil R. Reinstein gave a technical report on the administration of oral poliomyelitis vaccine. Dr. Reinstein moved that the Society go on record as favoring medical controls regarding the distribution of any product for human use or administration containing a live virus. Seconded by Dr. R. W. Holmes. Motion carried.

Dr. Benjamin Gitlitz then delivered the President's address which was most enthusiastically received by the House of Delegates.

Dr. Francis Barrett, reporting for the Time and Place Committee, stated that the dates for 1961 were September 18, 19, 20 and 21, at the Jackson Lake Lodge. The dates were discussed by the House and Dr. Barrett advised that after 1961 the week prior to Labor Day would be available on an annual basis. It was moved by Dr. Raymond E. Kunkel that the recommendations of the Time and Place Committee for next year and subsequent years be approved. Seconded by Dr. R. W. Holmes. Motion carried.

Dr. Gerald L. Smith, reporting for the Fee Schedule Committee, stated that it was recommended that the Veterans' Fee Schedule be revised so it would not be less than the Blue Shield rates. Dr. Smith stated that there had been a complete revision of the schedule for such things as house calls, administration of drugs, and so on, and that a complete list would be published and supplied to all doctors. Dr. R. W. Holmes moved that the report be accepted. Seconded by Dr. Silvio J. Giovale. Motion carried.

Election of officers

Dr. Benjamin Gitlitz announced the election of officers and turned the meeting to Dr. Francis Barrett, Chairman of the Nominating Committee. The Nominating Committee placed in nomination for President-elect, Dr. Frederick H. Haigler. Dr. Barrett then called for nominations from the floor. Dr. R. W. Holmes moved the nominations be closed and the Secretary authorized to cast a unanimous ballot for Dr. Haigler. Seconded by Dr. Silvio J. Giovale. Motion carried.

The Nominating Committee proposed the name of Dr. Silvio J. Giovale for Vice President. Dr. Barrett then called for nominations from the floor. Dr. Charles R. Lowe moved the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Giovale. Seconded by Dr. Paul J. Preston. Motion carried.

The Nominating Committee presented the name of Dr. John H. Froyd for Secretary. Dr. Barrett called for nominations from the floor. Dr. Dan B. Greer moved that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Froyd. Seconded by Dr. Ralph J. Malott. Motion carried.

The Nominating Committee placed in nomination Arthur R. Abbey for Executive Secretary. Dr. Barrett then called for nominations from the floor. Dr. H. B. Anderson moved that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Mr. Abbey. Seconded by Dr. Raymond E. Kunkel. Motion carried.

The Nominating Committee nominated Dr. Carleton D. Anton for Treasurer. Dr. E. Chester Ridgway moved the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Anton. Seconded by Dr. Frederick H. Haigler. Motion carried.

The Nominating Committee nominated Dr. Bernard J. Sullivan for Delegate to the A.M.A. Dr. Barrett then called for nominations from the floor. Dr. Dan B. Greer nominated Dr. R. W. Holmes. Dr. Holmes suggested that one should serve as Alternate before serving as Delegate and for that reason asked permission to withdraw. Such permission was granted and Dr. Frederick H. Haigler moved the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Sullivan. Seconded by Dr. R. W. Holmes. Motion carried.

The Nominating Committee nominated Dr.

After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.

As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.

Calm and relaxed, the patient is no longer upset by the pressures and irritations met in everyday life, nor is she likely to be incapacitated by autonomic disturbances, drowsiness, ataxia or other untoward reactions.

Alert and attentive, the patient participates in a P.T.A. meeting, following her second capsule of Meprospan-400 taken with the evening meal. Meprospan-400 does not decrease her mental efficiency or interfere with her normal activities or behavior.

Peacefully asleep, the patient enjoys beneficial rest . . . Meprospan-400 has relieved the tensions that previously prevented sleep or kept her tossing and turning throughout the night.

most widely prescribed tranquilizer . . .
most convenient dosage form . . .

ONE CAPSULE LASTS 12 HOURS

Meprospan®-400

400 mg. MILTOWN® SUSTAINED-RELEASE CAPSULES

Usual dosage: One capsule at breakfast lasts all day, one capsule with evening meal lasts all night. Supplied: Meprospan-400, each blue-topped *sustained-release* capsule contains 400 mg. Miltown. **Also available:** Meprospan-200, each yellow-topped *sustained-release* capsule contains 200 mg. Miltown. **For children:** Capsules can be opened and the coated granules mixed with soft foods or liquids.

Both potencies in bottles of 30.

Samples and literature available on request.

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Benjamin Gitlitz for Alternate Delegate to the A.M.A. Dr. Barrett then called for nominations from the floor. Dr. Charles R. Lowe nominated Dr. R. W. Holmes. There being no further nominations, a secret ballot was taken and Dr. Holmes was elected by a vote of 13-11.

The Nominating Committee placed in nomination the name of Dr. James E. Cashman for Advisory to Selective Service for a three-year term. Dr. Barrett then called for nominations from the floor. Dr. Raymond E. Kunkel moved the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Cashman. Seconded by Dr. R. W. Holmes. Motion carried.

Dr. Francis Barrett stated that two names would be submitted for one term as Blue Shield Trustees so that no vote was necessary, Dr. Dan B. Greer and Dr. H. B. Anderson. Dr. Barrett then called for further nominations from the floor. Dr. R. D. Arnold nominated Dr. Louis G. Booth. Dr. Frederick H. Haigler moved that the nominations be closed and that the three names be presented without a vote by the House of Delegates. Seconded by Dr. John H. Froyd. Motion carried.

The Nominating Committee nominated Dr. James W. Barber and Dr. Virgil L. Thorpe for three-year terms as Delegates to the Rocky Mountain Conference. Dr. Barrett called for nominations from the floor. Dr. E. Chester Ridgway moved the nominations be closed and the Secretary instructed to cast a unanimous ballot for Drs. Barber and Thorpe. Seconded by Dr. H. B. Anderson. Motion carried.

Past President Dr. H. B. Anderson conducted newly elected President Dr. Francis Barrett to the rostrum where he accepted the President's gavel.

Whereupon the meeting was adjourned.

A Thurber carnival in medicine

A routine check examination of a patient of Dr. Sidney Anderson in Alamosa by Dr. Walter Wasson, Radiologist, Denver, set the stage for a comedy of errors worthy of sharing. Dr. Wasson dictated his findings to his secretary and asked her to "mail them to Dr. Anderson." Obviously there was not a meeting of the minds as is evidenced by the following letter:

"September 13, 1960.

"Sidney Anderson, M. D.
"Alamosa, Colorado.
"My Dear Dr. Anderson:

"My correspondence with you has taken such an unusual turn that I wish to put it on record.

"Mrs. —— came back to me for a check examination. I made this examination and wrote a letter to you giving you my findings. This letter, however, was addressed to V. V. Anderson but was not sent to his home town of Del Norte, but to Monte Vista. The postmaster in Monte Vista used his head in place of the rubber stamp and sent the letter to V. V. Anderson in Del Norte. V. V. Anderson opened the letter, read its contents, looked up his records, and found he did not have a Mrs. —— as a patient. He then called you by long distance telephone and found that Mrs. —— was your patient and quite correctly sent the letter on to you. The Thurber Carnival had no better skit in Central City this summer than this interesting chain of events.

"I am sending a copy of this letter to the postmaster in Monte Vista with my compliments and to V. V. Anderson with my appreciation of his telephone call.

"Very sincerely yours,
"W. W. Wasson, M.D."

Imagine the fun folks in Colorado are going to have now that the State Society's President is Cyrus W. Anderson of Denver and the President-elect is V. V. Anderson of Del Norte.—Editor.

Mental illness decreases

The number of patients hospitalized for mental illness in this country has recently decreased, Health Information Foundation reports, after rising steadily for most of the century. There were 618,334 hospitalized mental patients in 1958, compared with 630,550 in 1955.

Course in Laryngology And Bronchoesophagology

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from March 13 through March 25, 1961, under the direction of Paul H. Holinger, M.D.

Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Rocky Mountain Traumatic Surgical Society

The Annual Meeting of the Rocky Mountain Traumatic Surgical Society will be held in Aspen, Colorado, on January 26, 27, and 28, 1961. The Trauma Committee of the American College of Surgeons (Rocky Mountain Section) will participate in this meeting, by invitation. Those interested in attending should contact the Aspen Travel Service for reservations, identifying the meeting.

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Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 265 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg. Supplied in bottles of 100 tablets.

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DIVISION OF ALLIED LABORATORIES, INC.
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As you like it . . . cont. from page 12

13. "Insulin treatment flourished for nearly 20 years, but its hazards, expense, and the failure of its empiricism to withstand critical inspection have all but resulted in its demise in 1958. Pyschosurgery, which reached its peak about 10 years ago, is nearly obliterated and only its staunchest advocates see any prospects for its continued use as a therapy in psychiatry." Gouda, Thomas A.: Psychiatry, in Annual Review of Medicine, edited by David A. Rytand and W. P. Creger, Palo Alto, Annual Reviews, Inc., 1959, Vol. 10, p. 291.

14. "That we do not see miliary lesions in the lung does not argue against the diagnosis. A number of patients who have shown miliary tuberculosis at autopsy have had no demonstrable lesions in good chest films." Wyman, Stanley M.: Discussion in Case 39251, Case Records of the Massachusetts General Hospital, New England J. Med. **248**:1067 (June 18), 1953.

15. "Confirmation of diagnosis of regional enteritis often requires careful x-ray examination of the small bowel. At times this examination may be facilitated by examining the patient when he has a full bladder, when some of the loops of ileum are raised out of the pelvis. In women with this disease, pregnancy may exert a beneficial influence, but in the postpartum period exacerbations are likely to occur." McCoombs, Robert P., editor: Clinical Notes from Medical Grand Rounds, Bull. New England Med. Center **13**:175 (August), 1951.

16. "Internal malignancy occasionally manifests itself by producing unusual signs in distant parts of the body, possibly by an allergic type of reaction. Examples are migrating thrombophlebitis, dermatomyositis, and arthritis." Ibid, **14**:64 (April-June), 1952.

17. "The diagnosis of reactivation of a peptic ulcer can be based more accurately on a typical history than on x-ray studies. When symptoms suggest activity of an ulcer, even though the x-ray film reveals only a scar, strict treatment should be promptly instituted." Ibid., **14**:100 (August), 1952.

Traffic safety

A study compiled by The Travelers Insurance Companies shows that speed was responsible for 12,980 traffic deaths in 1960—more than 43 per cent of the total.

Although making up less than 14 per cent of the driving population, drivers under age 25 were involved in nearly 29 per cent of all fatal accidents in the United States during 1959.

Cars that ran away—with no driver behind the wheel—killed 30 people in the United States last year, according to a report released by The Travelers Insurance Companies.

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Powdered opium U.S.P. (equivalent to paregoric 6 ml.)	24.0 mg.
Kaolin	6.0 Gm.
Pectin	142.8 mg.
Natural belladonna alkaloids	
hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz.

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The Colorado State Medical Society*

Midwinter Clinical Session, February 28 through March 3, 1961, Denver

President: Cyrus W. Anderson (Chairman of the Board), Denver.
President-elect: V. V. Anderson, Del Norte.
Vice President: Sam W. Downing (Vice Chairman of the Board), Denver.
Treasurer: William C. Service, Colorado Springs, 1962.
Constitutional Secretary: Howard T. Robertson, Denver, 1963.
Additional Trustees: Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961; Carl H. McLauthlin, Denver, 1962; J. Alan Shand, La Junta, 1963.
Delegates to A.M.A.: E. H. Munro, Grand Junction, 1961; (Alternate, Harlan E. McClure, 1961); I. E. Hendryson, Denver, 1961; (Alternate, C. C. Wiley, Longmont, 1961); Kenneth C. Sawyer, Denver, 1962; (Alternate, Gatewood C. Milligan, Englewood, 1962).
Executive Secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Colorado; telephone AComa 2-0547.

Montana Medical Association*

Interim Session, April 7-8, 1961
Helena

President: Raymond F. Peterson, Fullerton, Calif.†
President-elect: Everett H. Lindstrom, Helena.
Vice President: Harold W. Fuller, Great Falls.‡
Secretary-Treasurer: William E. Harris, Livingston.
Assistant Secretary-Treasurer: Albert L. Vadheim, Jr., Bozeman.
Executive Committee: Raymond F. Peterson, Butte; Everett H. Lindstrom, Helena; Harold W. Fuller, Great Falls; William E. Harris, Livingston; Albert L. Vadheim, Jr., Bozeman; Leonard W. Brewer, Missoula; Herbert T. Caraway, Billings.
Delegate to the A.M.A.: Paul J. Gans, Lewiston.
Alternate Delegate to the A.M.A.: S. C. Pratt, Miles City.
Executive Secretary: Mr. L. R. Hegland, P.O. Box 1692, Billings; telephone 9-2585.

Nevada State Medical Association*

Annual Meeting, August 23-26, 1961
Reno

President: Wesley W. Hall, Reno.
President-elect: James N. Greear, Jr., Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.
Delegate to American Medical Association: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.
Executive Committee: Wesley W. Hall, Reno; James N. Greear, Jr., Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Earl N. Hillstrom, Reno; John M. Moore, East Ely; John M. Read, Elko; William M. Tappan, Reno; Thomas S. White, Boulder City.
Executive Secretary: Mr. Nelson B. Neff, P.O. Box 2790, Reno; telephone FA. 3-6788.

New Mexico Medical Society*

Annual Meeting, May 17-20, 1961
Santa Fe

President: Allan L. Haynes, Clovis.
President-elect: William E. Badger, Hobbs.
Vice President: R. C. Derbyshire, Santa Fe.
Secretary-Treasurer: T. L. Carr, Albuquerque.
Speaker, House of Delegates: C. Pardue Bunch, Artesia.
Vice Speaker, House of Delegates: Omar Legant, Albuquerque.
Councilors: William Hossley, Deming, 1961; Guy E. Rader, Albuquerque, 1961; Robert P. Beaudette, Raton, 1962; William R. Oakes, Los Alamos, 1962; John McCulloch, Farmington, 1963; George Prothro, Clovis, 1963; Gerald Slusser, Artesia, 1963.
Delegate to American Medical Association: Earl L. Malone, Roswell; Alternate: Leland S. Evans, Las Cruces.
Executive Secretary: Mr. Ralph R. Marshall, 220 First National Bank Building, Albuquerque; telephone CH. 2-2102.

*Committee lists for all participating states will appear in subsequent issues.
†Resigned November 1, 1960.
‡Assumed the duties of the President, November 1, 1960, for the unexpired term of Dr. Peterson.

The Utah State Medical Association

Annual Session, September 13-15, 1961
Salt Lake City

President: Wallace S. Brooke, Salt Lake City.
President-elect: Ralph E. Jorgenson, Provo.
Secretary: John F. Waldo, Salt Lake City, 1963.
Treasurer: Edward R. McKay, Salt Lake City, 1963.
Councilors: Box Elder, D. L. Bunderson, Brigham City, 1960; Cache Valley, C. J. Daines, Logan, 1960; Carbon County, A. R. Demman, Helper, 1961; Central Utah, LaMar H. Stewart, Gunnison, 1962; Salt Lake County, R. W. Sonntag, Salt Lake City, 1960; Southern Utah, L. V. Broadbent, Cedar City, 1963; Uintah Basin, Vernon C. Young, Vernal, 1961; Utah County, Richard A. Call, Provo, 1963; Weber County, Wendell J. Thomson, Ogden, 1961.
Executive Committee: Wallace S. Brooke, Salt Lake City; I. Bruce McQuarrie, Ogden; Ralph E. Jorgenson, Provo; John F. Waldo, Salt Lake City; Edward R. McKay, Salt Lake City.
Delegate to American Medical Association: Drew M. Petersen, Ogden; Alternate: Stanley R. Child, Salt Lake City.
Executive Secretary: Mr. Harold Bowman, 42 South Fifth East Street, Salt Lake City 2; telephone EL. 5-7477.

See November, 1960, issue for complete list of committees.

Wyoming State Medical Society*

Annual Session, September 18-21, 1961
Jackson Lake Lodge

President: Francis A. Barrett, Cheyenne.
President-elect: Frederick H. Haigler, Casper.
Vice President: S. J. Giovale, Cheyenne.
Secretary: John H. Froyd, Worland.
Treasurer: C. D. Anton, Cheyenne.
Delegate to A.M.A.: B. J. Sullivan, Laramie; Alternate Delegate to A.M.A.: R. W. Holmes, Casper.
Executive Secretary: Mr. Arthur R. Abbey, Box 2266, Cheyenne; telephone 632-5525.

"And just what makes you think I've had too much to drink already?"

—The Road Toll by The Travelers Insurance Companies, 1959